DOB:

Driver's License #:

STATE OF WASHINGTON

DEPARTMENT OF LICENSING

*PO Box 9020, Olympia, WA 98507-9020*

# CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO THE DEPARTMENT OF LICENSING

I, _____ , authorize _____
PRINT PATIENT NAME — PRINT NAME OF PROGRAM MAKING DISCLOSURE

to disclose to the State of Washington, Department of Licensing, information regarding my alcohol and/or drug assessment, information school involvement, participation in treatment, progress in treatment, and program compliance and noncompliance. The purpose of this disclosure is to monitor my program involvement as a result of an alcohol and/or drug related license restriction, and may be used in arriving at a decision regarding my driving privilege in the State of Washington I further consent for this information to be redisclosed to the State of Washington, Department of Social and Health Services, Division of Alcohol and Substance Abuse, for purposes of chemical dependency program monitoring.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and, except as indicated above and otherwise provided for in the regulations, cannot be redisclosed without my written consent. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically 90 days following the date of termination of services from the program.

X _____
SIGNATURE OF PATIENT/CLIENT — DATE

X _____
SIGNATURE OF PARENT GUARDIAN or AUTHORIZED REPRESENTATIVE (when required) DATE

X _____
WITNESS — DATE

*The Department of Licensing has a policy of providing equal access to its services.*
*If you need special accommodation, please call (360) 902-3900 or TDD (360) 664-0116.*

ACRC-510-415 (R/4/97)OR