VERMONT
DEPARTMENT OF HEALTH

Impaired Driving Rehabilitation Program
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
Telephone: 802-651-1574
Fax: 866-272-7989

Impaired Driver Rehabilitation Program (IDRP)
Release of Confidential Information

- **I, _____, date of birth: _____/_____/_____, authorize:**

  - The Impaired Driver Rehabilitation Program (IDRP),
  - The Vermont Department of Motor Vehicles (DMV),
  - The Vermont Department of Corrections, including Probation & Parole (if applicable),
  - Applicable Vermont District or Superior Court(s),
  - Court Diversion and/or Teen Alcohol Safety Program (if applicable)

  to communicate with and disclose to one another information about the facts of my enrollment, current status, and completion of the IDRP School/therapy program. The amount of information disclosed will be the minimum amount necessary to satisfy the purpose. This information may include substance abuse treatment information for the purpose of determining:

  - Completion of requirements for the reinstatement of my driving privileges, and/or
  - Compliance with the conditions of my probation/parole, and/or
  - Other _____.

- **Please check any additional agencies/person(s) to whom information may be disclosed and received:**

  ☐ Spouse and/or other family member (MUST list names) _____
  ☐ Attorney (MUST give name) _____
  ☐ Department of Motor Vehicles in a State other than Vermont _____
  ☐ Counselor/Treatment facility _____
  ☐ Other person(s) _____

  By signing this form, I understand: my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise allowed by the regulations. IDRP will protect my information but there is the potential for information disclosed pursuant to this consent to be redisclosed by the recipient. I may revoke this consent at any time by contacting IDRP except to the extent it was already relied on. If not sooner revoked this consent expires automatically upon my release from probation/parole and/or upon reinstatement of my driving privileges. I am not required to sign this form to participate in IDRP but if I do not sign this form IDRP cannot share program completion information with DMV or any other party.

- **Signature of Participant: _____ Date: ____/____/_____**