BCCS
Brandywine Counseling & Community Services

To sign the *DSARP Client Consent to Release Information*, the client, parent/guardian/or authorized representative (if applicable), and witness must use:

1) Adobe Acrobat, Adobe Reader, or similar and a stylist, mouse, or touchscreen, or

2) print the form and sign.

Typing a name on the signature line is not permitted.

DSARP CLIENT CONSENT TO RELEASE INFORMATION

I, _____ , born _____hereby authorize the **Delaware Screening Assessment and Referral Program (DSARP),** to release to the following:

Sanare Today (formerly PACE), Open Door ,Thresholds, Connections, Brandywine Counseling, Delaware Department of Health and Social Services, DSAMH, Delaware Division of Motor Vehicles, Department of Public Safety, Office of Highway Safety (Electronic DUI Tracking System), Delaware Probation and Parole, Delaware Attorney General's Office, Delaware Court System

Other - Please use this space to allow us to release information to anyone else you wish (example: Attorney's name, Out of State Courts, Out of State DMV, Out of State Probation): _____

Out of State Referral agency: _____

The following information under these conditions:

(1) The consent can be revoked by the client at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it including the provision of services.

(2) The consent shall be valid for one year or the period reasonably necessary to accomplish the purpose for which it is given, whichever occurs first except that the consent remains valid for a period of five years for the limited purpose of providing historical DUI evaluation and recommendation results to a subsequent treatment agency, if the client returns for evaluation.

(3) Client is consenting to entering a program for DUI/DWI related charge(s)

(4) Client is consenting he/she was arrested and/or ticketed for DUI/DWI related charge(s)

(5) Client is acknowledging he/she was pulled over/stopped by law enforcement

Specific type of information to be disclosed:
Current or historical DUI evaluation and recommendation results; client status (for electronic tracking purposes); Client disposition as it relates to the above referenced agencies; re-disclosure of clinical documents received from other substance abuse and/or mental health treatment agencies.

Purpose for disclosure:
Confirm participation in DUI evaluation; referral to education and/or treatment program; report status to referral source; driver's license reinstatement; appeal process.

I AGREE THAT I HAVE READ AND UNDERSTAND THE ABOVE:

_____ _____
Signature of Client Date

_____ _____
Parent or Guardian or Authorized Representative Date

_____ _____
Signature of Witness Date

CONFIDENTIALITY OF ACOHOL AND DRUG ABUSE PATIENT RECORDS: The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser Unless: (1) The patient consents in writing; (2) The disclosure is allowed by court order, or (3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Violation of the Federal law and regulation by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. I understand that my records are also currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPPA), 45 C.F.R Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patients Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from re-disclosure. I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I understand that I am entitled to receive a copy of this authorization after it is signed.