

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
DUI INTERVENTION PROGRAM
Transfer of Clinical Evaluation to Treatment Provider

I, _____, authorize
(Name of Client)

(Name of DBHDD Clinical Evaluator)

to disclose to the Georgia Department of Behavioral Health & Developmental Disabilities, Division of Addictive Diseases, DUI Intervention Program Treatment Provider the following information containing the results of my clinical evaluation as shown on the DUI Offender Case Presentation Form and any other necessary information about my DBHDD Clinical Evaluation. I am selecting the following DBHDD Treatment Provider:

(Name of DBHDD Treatment Provider)

The purpose of the disclosure authorized herein is to permit the transfer of my record to the DBHDD Treatment Provider of my choice.

I understand the transfer of my record can only take place by mailing or faxing a copy to the DBHDD Treatment Provider, and will be accomplished within five (5) business days of the signature of this release

I also understand that only the Clinical Evaluation can be released.

Re-disclosure of the NEEDS Assessment is not permitted unless I authorize transfer.

Please initial below:

I authorize transfer of NEEDS Assessment
 I do not authorize transfer of NEEDS Assessment

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 cannot be disclosed without my written consent unless otherwise provided for in the regulations. 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 as follows:

(Six) 6 months after the completion of my clinical evaluation or _____
(Expiration Date)

Client Signature

Date