

INTOXICATED DRIVER RESOURCE CENTER

Monmouth County IDRC

PO Box 3000

Freehold, NJ 07728

Phone: (732) 308-3713

Fax: (732) 625-3907

RECORDS RELEASE AUTHORIZATION

I hereby consent to the release from my records of the information specified below. 10:162-4.8H.

CLIENT NAME	CLIENT'S DRIVERS LICENSE NUMBER
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The purpose of this release is to communicate with and disclose to one another the following information: to report compliance with the Intoxicated Driving Program, or for any purpose authorized under N.J.S.A. 39:4-50 and other Motor Vehicle Commission and Division of Addiction Services statutes and regulations.

The agencies authorized to make the release are:

- The New Jersey Motor Vehicle Commission;
- The New Jersey Division of Addiction Services;
- The sentencing court;
- Any Intoxicated Driver Resource Center;
- Attorney, if applicable;
- MAKE SURE "X" IN BOX & TREATMENT PROVIDER'S NAME (indicate treatment agency/provider)
- Other: MAKE SURE "X" IN BOX & INDIVIDUAL THAT PERMISSION IS GRANTED FOR IDRC TO SPEAK WITH.

The kind and amount of information to be released are only those records necessary for compliance/non-compliance reports regarding completion with IDRC requirements to complete sentencing or program requirements.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from proceedings with the IDRC.

To recipient of this information:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Name of Client or Person Authorized by Law to Give Consent CLIENT PRINT NAME	Signature CLIENT SIGN NAME	Date DATE
Witness WITNESS PRINT NAME (anyone)	Signature WITNESS SIGN NAME	Date DATE