VASAP CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION – GENERAL

Probationer: _____ **Date of Birth:** _____

(Your Name)

I hereby grant the Virginia Alcohol Safety Action Program (VASAP) consent to exchange information with:
-the court of record/referral
-the Commonwealth Attorney's office
-attorney(s) of record
-local, state, and federal law enforcement agencies
-other criminal justice entities
-the Virginia Department of Motor Vehicles
-applicable VASAP ignition interlock service providers and remote alcohol service providers

For the purpose of facilitating, supervising, verifying, and reporting my participation in, and compliance with ASAP requirements.

I understand that I am being referred to the Alcohol Safety Action Program **by a court.** Information concerning my participation will be reported to the court, and my consent for that purpose will terminate upon successful completion of my ASAP probation. In the event of noncompliance, this Consent for Release of Confidential Information will not expire until the referring court formally terminates the Alcohol Safety Action Program's oversight of the case.

I understand that I am enrolling in the Alcohol Safety Action Program to complete a **DMV requirement.** This Consent for the Release of Confidential Information shall expire automatically upon termination of my ASAP participation.

I understand that my records are protected under the Federal Confidentiality Regulations (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I further understand that all **treatment** information is protected under HIPAA and cannot be released by the ASAP without my consent; however, should I elect to transfer to another ASAP, all records to include treatment records will be sent to the supervising ASAP in order to effectively administer my case. A copy of this Consent for Release of Confidential Information form shall be considered to be valid as the original.

Executed this _____ **day of** _____**, 20**_____

Participant's Signature: _____

Parent/Guardian Signature: ***(required if under the age of 18):*** _____

To revoke consent for release of information, complete this section.
Date Revoked: _____

Participate Signature: _____

Parent/Guardian Signature *(if required)*: _____

PROHIBITION ON RE-DISCLOSURE: 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 information is not sufficient for this purpose.