

VASAP CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION – INDIVIDUAL

Probationer: _____
(Your Name)

Date of Birth: _____

I hereby grant the Virginia Alcohol Safety Action Program (VASAP) consent to exchange information with the following individual:

(Name of Person With Whom to Share Your Information) (Phone Number) (Password)

for the purpose of informing them, upon their request, of all information pertaining to my participation in ASAP to which they would not otherwise be legally entitled.

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.