Mpango wa Usaidizi wa Madereva Walevi
Utoaji wa Taarifa za Siri

Machi 2024

Mimi, _____, na niliyezaliwa tarehe ____ /____ /____, ninaidhinisha:

- Mpango wa Usaidizi wa Madereva Walevi (IDRP),
- Idara ya Magari ya Vermont (DMV),
- Mahakama Husika ya(za) Wilaya au ya(za) Juu ya(za) Vermont,
- Idara ya Marekebisho ya Vermont, pamoja na Majaribio na Ahadi ya Kutotoroka (ikiwa inatumika),
- Mpango wa Kutohusisha Mahakama na/au Mpango wa Usalama Dhidi ya Pombe kwa Vijana (ikiwa unatumika)

kuwasiliana na kutoa taarifa kati yao kuhusu maelezo ya uandikishaj, hali na ukamilishaji wangu wa mpango wa elimu/matibabu wa IDRP. Kiasi cha taarifa zitakazofichuliwa kitakuwa kiwango cha chini zaidi kinachohitajika ili kukidhi kusudi. Taarifa hizi zinaweza kujumuisha maelezo ya matibabu ya matumizi ya dawa za kulevya kwa madhumuni ya kuamua kama:

- Nimekamilisha masharti ya kurejeshwa kwa haki zangu za kuendesha gari, na/au
- Nimetii masharti ya majaribio/ahadi yangu ya kutotoroka, na/au
- Mengine: _____

Tafadhali chagua watu au mashirika yoyote ya ziada ambayo IDRP inaweza kufichua au kushiriki taarifa kuhusu maendeleo yako ya IDRP. Hii inaweza kujumuisha mwanandoa, mwanafamilia, wakili, mshauri, au DMV ya Jimbo lingine. IDRP haitajadili uandikishaji/ukamilishaji wako wa IDRP na mtu yeyote au kutuma uthibitisho wa kukamilisha kwa Jimbo lingine bila idhini ya maandishi.

☐ Mwanandoa/Mwanafamilia/Rafiki (lazima uandike jina/majina): _____
_____

☐ Mwanasheria (lazima uandike jina): _____

☐ Mshauri/Mtoa Huduma ya Matibabu: _____

☐ Mtu/watu wengine: _____

☐ Idara ya/za Magari nje ya Vermont:
Jimbo: _____
Anwani: _____
Faksi/Barua pepe: _____

☐ Ninaidhinisha IDRP kuwasiliana nami kupitia barua pepe na ninaelewa kwamba mawasiliano haya hayawezi kuhakikishiwa kuwa salama au ya siri.

Anwani ya barua pepe: _____

Kwa kusaini fomu hii, ninaelewa kuwa: rekodi zangu za matibabu ya pombe/dawa za kulevya zinalindwa chini ya kanuni za serikali kuu zinazosimamia Usiri wa Rekodi za Wagonjwa wa Matumizi ya Dawa za Kulevya, 42 C.F.R. Sehemu ya 2, na Sheria ya Uhamishaji na Uwajibikaji wa Bima ya Afya ya 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 na haziwezi kufichuliwa bila idhini yangu ya maandishi isipokuwa kama inaruhusiwa vinginevyo na kanuni. IDRP italinda taarifa zangu lakini kuna uwezekano wa taarifa zilizofichuliwa, kulingana na idhini hii, kufichuliwa tena na mpokeaji. Ninaweza kubatilisha idhini hii wakati wowote kwa kuwasiliana na IDRP isipokuwa kwa kiwango ambacho tayari imetumika. Ikiwa sitaibatilisha mapema, idhini hii itaisha moja kwa moja baada ya kuachiliwa kwangu kutoka kwa majaribio/ahadi ya kutotoroka na/au baada ya kurejeshwa kwa haki zangu za kuendesha gari. Sihitajiki kusaini fomu hii ili kushiriki katika IDRP lakini ikiwa sitasaini fomu hii, IDRP haiwezi kushiriki taarifa za kukamilisha mpango na DMV au mhusika mwingine yeyote.

Saini ya Mshiriki: _____ Tarehe: _____

Impaired Driver Rehabilitation Program
Release of Confidential Information

March 2024

I, _____, with date of birth ____ /____ /____, authorize:

- The Impaired Driver Rehabilitation Program (IDRP),
- The Vermont Department of Motor Vehicles (DMV),
- Applicable Vermont District or Superior Court(s),
- The Vermont Department of Corrections, including Probation & Parole (if applicable),
- Court Diversion and/or Teen Alcohol Safety Program (if applicable)

to communicate with and disclose to one another information about the facts of my IDRP enrollment, status, and completion of the IDRP education/treatment program. The amount of information disclosed will be the minimum amount necessary to satisfy the purpose. This information may include substance use treatment information for the purpose of determining:

- Completion of requirements for the reinstatement of my driving privileges, and/or
- Compliance with the conditions of my probation/parole, and/or
- Other: _____

Please select any additional organizations or people to which IDRP may disclose or share information about your IDRP progress. This might include a spouse, family member, attorney, counselor, or another State's DMV. IDRP will not discuss your IDRP enrollment/completion with anyone or send proof of completion to another State without written authorization.

☐ Spouse/Family Member/Friend (must list name(s)): _____
_____

☐ Attorney (must list name): _____

☐ Counselor/Treatment Provider: _____

☐ Other person(s): _____

☐ Department(s) of Motor Vehicles outside Vermont:
State: _____
Address: _____
Fax/Email: _____

☐ I authorize the IDRP to communicate with me via email and understand that these communications cannot be guaranteed as secure or confidential.

Email address: _____

By signing this form, I understand: my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise allowed by the regulations. IDRP will protect my information but there is the potential for information disclosed pursuant to this consent to be redisclosed by the recipient. I may revoke this consent at any time by contacting IDRP except to the extent it was already relied on. If not sooner revoked this consent expires automatically upon my release from probation/parole and/or upon reinstatement of my driving privileges. I am not required to sign this form to participate in IDRP but if I do not sign this form IDRP cannot share program completion information with DMV or any other party.

Participant Signature: _____ Date: _____