



County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

YEAR OF ARREST: _____

SOCIAL SECURITY #: _____

I hereby give consent to Fairfax Alcohol Safety Action Program to release to _____ the following information:

- _____ (1) Intake/legal and social history including arrest date, questionnaires, record checks, and client evaluation.
- _____ (2) Counseling progress notes including on-going evaluation, program referrals, and referral reports.
- _____ (3) Medical or mental health records on file, including breath, blood or urine reports while in the program.
- _____ (4) Closing summary.

This information is being obtained for (state reason): _____.

This consent is subject to revocation at any time except to the extent that the Fairfax Alcohol Safety Action Program has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: _____

(specific date, event or condition)

(Date)

(Signature of Defendant)

OR: Signature of a person authorized to give consent under 42 C.F.R. §2.14 when the patient is a minor; or, signature of a person authorized to sign under 42 C.F.R. §2.15 in lieu of the patient when the patient is incompetent or deceased.

(Date)

(Signature of Witness)

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.

Fairfax County Alcohol Safety Action Program

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Fairfax, VA 22030

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