OWI-321J

CONSENT TO RELEASE ALCOHOL AND DRUG ABUSE INFORMATION

I, ____ authorize:
(Client Name-Please Print or Type)

Employee and Family Resources
(Name of Organization, Substance Abuse Treatment Program, or Person to Release the Information)

505 5th Avenue, Suite 600, Insurance Exchange Building
(Address)

Des Moines, IA 50309
(City) (State) (Zip)

to release the information specified below to :

Iowa Department of Transportation
Iowa Motor Vehicle Division Bldg.
6310 SE Convenience Blvd
Ankeny, IA 50021

Information to be released:

	YES	NO
Duration of Program involvement and attendance	☐	☐
Summary of treatment participation	☐	☐
Evaluation results and recommendations	☐	☐

Other (specify)____

The only purpose(s) for the disclosure of the above information is:

_______Facilitate compliance regarding OWI (321J) and DOT requirements.
_______Other (specify)____

I voluntarily allow the release of the above named information. No threat or other coercive measures have induced me to sign this consent form. I understand this information will not be forward to anyone else by the recipient without my written consent. I have been informed concerning current federal confidentiality regulations regarding alcohol and drug abuse patient records.

This authorization is effective for 6 months after the date it is signed: or, ___________________________
(specify date, event, or condition upon which the consent expires)

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken on the basis of this release. Disclosure of information can be verbal or written and can include copies of clinical reports.

____ ______________________
(Client's Signature) (Date)

____ ______________________
(Witness' Signature) (Date)