STATE OF WASHINGTON
DEPARTMENT OF LICENSING
Olympia, Washington 98504-8001

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION TO THE DEPARTMENT OF LICENSING

Follman Agency LLC
910 South Anacortes Street
Burlington, WA 98233

I, _____, authorize _____
NAME OF PATIENT — NAME OF PROGRAM MAKING DISCLOSURE

to disclose to the Washington State Department of Licensing information regarding my alcohol and/or drug assessment, information school involvement, participation in treatment, progress in treatment, and program compliance and non-compliance. The purpose of this disclosure is to monitor my program involvement as a result of an alcohol and/or drug related license restriction, and may be used in arriving at a decision regarding my driving privilege in the State of Washington. I further consent for this information to be re-disclosed to the Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, for purposes of chemical dependency program monitoring.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and, except as indicated above and otherwise provided for in the regulations, cannot be re-disclosed without my written consent. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically 90 days following the date of termination of services from the program.

_____ _____
SIGNATURE OF PATIENT/CLIENT — DATE

_____ _____
SIGNATURE OF PARENT, GUARDIAN, OR AUTHORIZED REPRESENTATIVE, WHEN REQUIRED — DATE

_____ _____
WITNESS — DATE