

# 違規駕駛員康復計劃 機密資訊的披露

2024 年 3 月

本人，\_\_\_\_\_，出生日期 \_\_\_\_/\_\_\_\_/\_\_\_\_，授權：

- 違規駕駛員康復計劃 (IDRP)
- 佛蒙特州機動車輛管理局 (DMV)、
- 適用的佛蒙特州地區法院或高等法院、
- 佛蒙特州懲教部，包括緩刑和假釋 (如適用)、
- 法庭分流和/或青少年酒精安全計劃 (如適用)

相互交流並披露有關我的 IDRP 註冊、狀態和 IDRP 教育/治療計劃完成情況的資訊。披露的資訊量將是滿足目的所需的最低程度。此資訊可能包括物質使用治療資訊，以確定：

- 完成要求以恢復我的駕駛權力，和/或
- 遵守我的緩刑/假釋條件的情況，和/或
- 其他：\_\_\_\_\_

請選擇 IDRP 可能向其披露或共用您的 IDRP 進度資訊的任何其他組織或個人。這可能包括配偶、家庭成員、律師、顧問或其他州的 DMV。未經書面授權，IDRP 不會與任何人討論您的 IDRP 註冊/完成情況，也不會將完成證明發送到另一州。

- 配偶/家庭成員/朋友 (必須列出姓名)：\_\_\_\_\_
- 律師 (必須列出姓名)：\_\_\_\_\_
- 輔導員/治療提供者：\_\_\_\_\_
- 其他人士：\_\_\_\_\_
- 佛蒙特州以外的其他州機動車輛管理局 (DMV)：  
州：\_\_\_\_\_
- 地址：\_\_\_\_\_
- 傳真/電子郵件：\_\_\_\_\_

- 我授權 IDRP 透過電子郵件與我溝通，並理解不能保證這些溝通安全或保密。

電子郵件：\_\_\_\_\_

我簽署此表格，即表示，我瞭解：我的酒精和/或藥物治療記錄受聯邦法規《物質使用障礙患者記錄保密性》42 C.F.R. 第 2 部分以及 1996 年《健康保險流通與責任法案》(HIPAA) 45 C.F.R. 第 160 & 164 部分的保護，並且，除非法規另有規定，否則，未經我的書面同意不得披露。IDRP 將保護我的資訊，但根據本同意披露的資訊有可能被接受者重新披露。我可以隨時透過聯繫 IDRP 撤銷此同意，但已經依據本同意書披露的情況除外。如果未提前撤銷，此同意將在我緩刑/假釋釋放和/或恢復駕駛權力後自動失效。我不需要簽署此表格即可參加 IDRP，但如果我不簽署此表格，IDRP 將無法與 DMV 或任何其他方共用計劃完成資訊。

參與者簽名：\_\_\_\_\_

日期：\_\_\_\_\_

Traditional Chinese

# 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: \_\_\_\_\_

English