

REPORT OF ADDICTION TREATMENT

North Dakota Department of Transportation, Drivers License
SFN 9997 (9-2019)

DRIVERS LICENSE DIVISION
ND DEPARTMENT OF TRANSPORTATION
608 E BOULEVARD AVE
BISMARCK ND 58505-0750

CONFIDENTIAL
For Department of Transportation
Use Only

The **ADDICTION/EDUCATION PROGRAM** is to mail this completed form within 5 working days following client completion or termination of the program.

FROM:

REGARDING:

Licensed Addiction Treatment Program/Counselor/Qualified Professional			Patient/Driver's Name			Telephone Number		
Address			Address			Date of Birth		
City	State	ZIP Code	City	State	ZIP Code			
Qualified Professional (LAC, PhD, LPCC, LCSW)			Drivers License Number (DLN)					

Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. The Department of Human Services will not condition treatment on your agreement to authorize disclosure of your health information. The Department of Human Services may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department of Human Services health plan.

VERIFICATION OF TREATMENT

The above-named patient/driver enrolled in the prescribed treatment/education program listed above on _____ (date of enrollment), and fulfilled the attendance rules of the program on _____ (date of completion).

- | | | |
|---|--|---|
| <input type="checkbox"/> 16-Hour DUI Seminar | <input type="checkbox"/> Day Treatment/PHP | <input type="checkbox"/> High Intensity Residential |
| <input type="checkbox"/> Outpatient Services | <input type="checkbox"/> Inpatient | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Intensive Outpatient | <input type="checkbox"/> Low Intensity Residential | |

Qualified Professional Signature	License Number	Date
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Remarks

RELEASE OF INFORMATION

I, the above-named patient/driver certify this report of addiction evaluation form was completed at my request to comply with the North Dakota Department of Transportation statutory requirements. I authorize the treatment program and/or addiction counselor herein named to release in writing information of my evaluation/recommendations to the Drivers License Division, North Dakota Department of Transportation.

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 cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time by providing written notice to the agency or person except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Specify the date, event, or condition upon which this consent expires

Notice to Whomever Disclosure is Made Concerning Addiction Records

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 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.

Patient/Driver Signature	Date
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DISTRIBUTION:

At enrollment copy goes to: Drivers License Division
At completion of treatment/education **original** goes to: Drivers License Division
Copies to: Patient/Driver and Treatment/Education Program