# Contact Counseling

Bob Chambers MA CDP
Director

1118 Finnegan Way, Ste 103
Bellingham, WA 98225

Phone: (360) 671-3277
Fax: (360) 733-9499

Instructions for Reinstating your Driver's License

**Contact Counseling assumes that by sending a completed release of information to us, you would like your information sent to the Washington State Department of Licensing.**

If you would like your assessment sent to the Washington State Department of Licensing, please follow the directions outlines below:

- Confirm with your attorney and/or probation officer that it is the appropriate time to reinstate your license. Please note that if this information is sent to the DOL too early (i.e. pre-trial), you may lose your license prematurely.

- Print and complete the release of information (page 2 of this document) authorizing an exchange of information with the DOL. Please note that if the release is in any way incomplete, we may not be able to process your information. On the release of information be sure to include the following:
  - Your full name and date of birth
  - Your initials where indicated
  - Your signature and the date signed
  - The signature of a witness (this can be anyone over the age of 18, even a friend or co-worker)
  - Your phone number and approximant date of your assessment.

- Contact Counseling will also need a clear copy or photo of your Washington State driver's license or ID card. It is okay if it is expired or has a hole punched in it, we just need it for the information.

- In addition:
  - If you have ADIS requirements, please be sure that the facility that hosted the ADIS class sends in proof of your attendance to the DOL;
  - Or, if you have treatment requirements, please be sure that the treatment center where you attended classes sends in proof of your attendance to the DOL.

Please note that other than assuring that the information we send is accurate, there is little we can do to expedite processing times at the DOL.

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Once complete please return the release of information and copy of your license to Contact Counseling by email to contactc4u@gmail.com, by fax to (360) 733-9499, or simply mail the release to:

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Please do not hesitate to be in touch with any questions at (360) 671-3277, we are happy to help.

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## DISCLOSURE AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ DOB: _____, hereby authorize an exchange of
(Full Name of Participant)

information between Contact Counseling and Washington State Department of Licensing.
(Name of person/agency obtaining/receiving information, & relevant contact information)

Please **initial** the substance abuse information to be obtained, release and/or exchanged:

_____ Assessment (Allows the person/agency listed above to receive details of your assessment, in writing or verbally, at the discretion of Contact Counseling. This may include details of the conversation, results of testing, and treatment recommendations)

_____ Collaborative Information (Allows the person/agency listed above to provide additional information to Contact Counseling for your assessment)

_____ Scheduling Assistance (Allows the person/agency listed above to assist you with scheduling, payment, and translation as needed)

_____ Other (specify): _____.

Please **initial** the purpose or need for the exchange and disclosure of this information:

_____ Facilitate Treatment _____ Summarize Recommendation _____ Consultation

_____ Other (specify): _____.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and 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 provided for by the regulations.

I also understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it. Unless revoked earlier, I understand, that from the date of signing, this release shall expire as specified below:

6 months.

I understand my treatment may not be conditioned on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____ _____
Participant Signature Date

_____ _____
Parent or Guardian (for minors) Date

_____ _____
Witness Date

In case we need to get in touch, please provide:

Participant Phone: _____

Date or Year of Assessment: _____