Florida Safety Council

1505 East Colonial Drive Orlando, FL 32803 (407) 896-1894 Fax (407) 897-4471

Treatment Referral and/or Documentation

Name _____ **D.O.B.** _____

Last Name *First Name* *Middle Name*

Address _____ **Phone** _____

_____ **Evaluation Date** _____

In conjunction with my enrollment at Florida Safety Council under the provisions of sections 316.192, 316.193, 322.271, or 322.291, Florida Statutes, and as a result of my evaluation, I am required to participate in treatment. I hereby grant permission to Florida Safety Council to disclose and deliver the following:

- [X] Completed Client Data Information and Interview (HSMV77004)
- [X] This signed Treatment Referral Form (HSMV77005)
- [X] Feedback Form (HSMV77031)
- [X] Specify Other DD / Incidents / correspondence.

to the provider named below for the purposes of assisting in my participation in treatment:

Provider Name _____

Provider Address _____

Provider Contact Person _____ **Telephone Number** _____

Best Hours to Contact _____ Fax:

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: Specific Date, Event or Condition)

A copy of this consent is as valid as the original. I hereby grant permission to Florida Safety Council to obtain from the treatment provider listed above, the following information: Proof of enrollment; Copy of initial treatment plan; Feedback Form to be enclosed whenever mailing documents to our agency, and when there is a change in client status; and Narrative, individualized Discharge Summary for the purpose of continuity of care.

This information has been disclosed to you from records protected by the 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 the 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.

I understand that I have been referred for the reasons checked below to this agency, and I acknowledge Florida Safety Council has explained to me the reasons for this referral to treatment.

- [X] Drinking related concerns
- [ ] Drug related concerns
- [ ] Health related concerns
- [ ] Personal concerns
- [ ] Family related concerns
- [ ] After care needs
- [ ] Antabuse program
- [ ] Other _____

I have selected a treatment agency that was most convenient for me based on cost, location, or other personal factors. I have been informed of the requirement to complete the referral and that the DHSMV shall be notified, should I fail to complete the referral.

I understand that the Florida Safety Council will require this treatment until the treatment provider has determined that it is appropriate to release me from treatment. Such treatment resulting from the DUI Program's psychosocial evaluation may not be waived without a supporting psychosocial evaluation conducted by a treatment provider appointed by the court and with access to the original evaluation.

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Clients who initially enrolled in the DUI Program prior to adjudication and were referred to treatment but did not keep their scheduled appointment will be required to come to this office to execute a new referral appointment within (20) twenty days of adjudication. A $15.00 fee shall be assessed for this service. Clients who choose to transfer to a different agency will be required to come to this office to execute a new referral. A discharge summary or recommendation from the original treatment provider is required. A $15.00 fee shall be assessed for this service.

Clients who have any problems regarding this referral or the services provided by the treatment provider listed above, are to call the DUI Program for resolution of any problems. Client shall initial the appropriate statement:

a. ☐ I understand that an appointment has been made for me with the above agency at _____ on _____ .

b. ☐ I understand that I must have an appointment with the above agency no later than _____ (20 days from evaluation).

c. ☐ It is my responsibility to ensure that documentation of my previous completion of treatment is received by the above named DUI Program. If documentation is not received by the DUI Program, I am aware that my license will be cancelled.

d. ☐ I am currently in treatment and I understand that the above named DUI Program will confirm my participation with the above named treatment provider.

My signature below authorizes and confirms my awareness of the requirements, information and disclosure provisions on pages 1 and 2.

X _____	_____	_____
Client Signature	**Parent / Guardian Signature**	**Evaluator Signature**
X _____	_____	_____
Date	**Date**	**Date**