**DWI/DUI/DWAI Rights**

1. If you are coming to me for a DWI/DUI/DUAI or Substance Use Moving Violation (SUMV) assessment, during our first session, as per the Office of Alcoholism and Substance Abuse Services (OASAS, the NYS DWI/Substance Abuse governing body) please bring with you:
   * A copy of your Arrest Report (your lawyer or the arresting precinct should have a copy)
   * A copy of your Driver’s abstract (Obtainable at DMV or at DMV.US.org)
   * Your driver’s license or your Driver’s license number
   * At least 2-3 releases signed (see below)
2. As per OASAS, I will need to get a release for a collateral (second release below); someone who can discuss with me your drinking and your driving habits. They can be a friend, relative, professional, or legal contact. I will also need a release for your referral source (third release below if there is a referral source) such as a probation or parole officer, case manager, TASC case manager, or whomever you will need me to correspond with in relation to your SUMV case. If there is no referral source, that is OK, not everyone has one. I also need a release for OASAS (first release below) so I can both complete your SUMV related paperwork and put you into the Impaired Driver’s system (IDS). This is the system that DMV uses to view my conclusion if treatment is required and whether treatment has concluded. Without this release, I cannot inform DMV you are in or out of treatment or have even been assessed. An OASAS approved tool called LOCADTR 3.0 (Level of care for Alcohol and Drug Treatment Referral) must also be conducted, this release allows me to utilize that tool.
3. After your assessment, I may provide you treatment recommendations. You can choose to be re-assessed by another provider. You do not have to take my recommendations. I will not change my recommendations once I have provided them without a sufficient reason. However:
4. It can take up to two weeks to get back to you with regards to whether treatment is required. Normally, this is because I am waiting for toxicology results, or I have not spoken with your collateral source. Once I have all my information, I will inform you and your referral source as to the outcome.
5. As part of the assessment and at least once a week should you require treatment, I will ask you to provide toxicology samples at Quest laboratories. There are several located nearby my Mineola office. The two closest facilities are 520 Franklin Ave Ste 104, Garden City, NY 11530 and 212 Station Plaza, Mineola NY 11501. You may be able to utilize your insurance to pay for the lab or you can self-pay. The results will be mailed to my office and a copy put in your file. The results usually take about 1 week to get, but I have no control over that. When I give you paperwork to bring to Quest, please provide a specimen within 24 hours.
6. Said toxicology results will be shared with your referral source if you have one. If you choose to revoke your release for your referral source, I cannot share any information with them. However keep in mind that when a referral source hears “I can’t confirm or deny who you are talking about,” (the typical response provided without a release) they usually know that means a release was revoked or was never provided and may take disciplinary measures against you.
7. I may breathalyze you during any session for any reason. You may refuse. If you are positive or refuse and you drove to my office, I will ask for your keys. If positive, I will and continue to breathalyze you until the reading is zeroed out. Whether positive or you refuse, you are free to call someone to pick you up, call a ride share service, use public transportation, etc., when leaving my office. We can talk about how you will get your keys back if you chose to do this. However, I cannot forcibly take them, nor do you have to give them to me. If you chose to leave with your keys, I will do what I can to report to the police that I suspect that you are drinking and driving and why. I have a duty to warn and to protect the public, this is not negotiable.
8. You are welcome to invite family members into sessions after the assessment.
9. I am a NYS Credentialed Alcohol and Substance Abuse Counselor (CASAC). Any complaints you have against my credential can be filed at <https://www.oasas.ny.gov> or call 518-473-3460.
10. I may (probably will) make a lot of suggestions throughout the counseling relationship. You do not have to take any suggestions, you do not have to do anything I say. However, if no/minimal suggestions are taken and nothing appears to be changing, I will probably ask you if our working relationship is beneficial to you and I may provide referrals. I don’t want to waste your time, risk your health, or safety.

**DWI/DUI/DWAI Responsibilities**

1. Please show up to sessions, on time, resolve any copays or fees, and participate.
2. Please be honest with me in session.
3. Please let me know if you relapse or use any mind/mood altering substances.
4. I strongly suggest that while in counseling for a SUMV, you do not consume alcohol or use any drugs that are not prescribed to you. Any positives for anything not a medication previously discussed will be documented in any reports written for referral sources and could prolong treatment and increase your legal consequences.
5. I strongly suggest you read labels before using any product including but not limited to mouthwash, hand sanitizer, and over the counter medications. The legal system has little tolerance for false positives.
6. When being assessed, please tell me all substances you are currently using/abusing, any you have used/abused in the last year, and any that you think you may have had a problem with in the past.
7. If you are prescribed any medical or mental health medication from an outside source, I will ask for releases of information for those sources to confirm the prescriptions and inquire if there has been a history of abusing that medication. This includes but is not limited to Opioid agonist/antagonist medication, Benzodiazepines, amphetamines, and Vivatrol shots. I suggest you sign a release with your providers for my office.
8. If/when paperwork is given to you for toxicology screens, please provide a sample within 24 hours. The results will tell me when a sample was provided. I will share the results with you if you ask, or if there is a positive for any substance.
9. Social media and reviews: Should you choose to post, like, review, comment, etc., on any online or print forum/platform, anything related to myself or my practice, please understand you may be publicly giving up your confidentiality as a client of mine. You do so at your own risk.
10. By signing below, you acknowledge that I have provided you a copy of your rights, and you acknowledge your responsibilities as a SUMV client. This form will be kept in your file in my office and your chart.

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Print name Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB Today’s Date

Larry Epstein Mental Health PLLC

**302 Willis Avenue**

**Mineola NY 11553**

**(O)516-325-5617 (F)516-741-8456**

### Release of Information to the Office of alcoholism and Substance Abuse Services Authorized personnel

I hereby authorize Larry Epstein LMHC CASAC to exchange information with:

Name: **OASAS (Office of Alcoholism and Substance abuse services)**

Address: 1450 Western Avenue, Albany, NY 12203

Telephone: 518-473-3460

The information requested or authorized for release or exchange pertains to:

* Results of Treatment

Other diseases or ailments

* Progress of Treatment/counseling
* Drug/alcohol abuse
* Admit date
* Discharge date
* Discharge status
* Impaired Driver System (IDS)
* LOCADTR 3.0

This authorization is valid for 1 year from the date provided below or **\_\_\_\_\_\_\_\_\_\_\_**, whichever is earlier. I may cancel this authorization by signing, dating, and writing “CANCEL” on this original form, by sending a written, signed and dated request to the counselor above indicating my desire to cancel or verbally informing him of my desire to rescind this release. I understand that once my information has been released, the recipient might re-disclose it, my counselor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

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 understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### Client’s Name Date of Birth

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##### Client’s Signature Today’s Date

Larry Epstein Mental Health PLLC

**302 Willis Avenue**

**Mineola NY 11553**

**(O)516-325-5617 (F)516-741-8456**

### Release of Information for a collateral call (as mandated by OASAS)

I hereby authorize Larry Epstein LMHC CASAC to exchange information with:

Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

The information requested or authorized for release or exchange pertains to:

* Drinking/Drugging habits
* Driving habits
* Assessment results
* Drug/alcohol abuse
* Answer collateral’s questions

This authorization is valid for 1 year from the date provided below or **\_\_\_\_\_\_\_\_\_\_\_**, whichever is earlier. I may cancel this authorization by signing, dating, and writing “CANCEL” on this original form, by sending a written, signed and dated request to the counselor above indicating my desire to cancel or verbally informing him of my desire to rescind this release. I understand that once my information has been released, the recipient might re-disclose it, my counselor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

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##### Client’s Name Date of Birth

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##### Client’s Signature Today’s Date

Larry Epstein Mental Health PLLC

**302 Willis Avenue**

**Mineola NY 11553**

**(O)516-325-5617 (F)516-741-8456**

### Release of Information for an outside entity

I hereby authorize Larry Epstein LMHC CASAC to exchange information with:

Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information requested or authorized for release or exchange pertains to:

Confirm appointments

Toxicology results/admission of use

Progress of Treatment/counseling

Answer drug/alcohol abuse questions

Other\_\_\_\_\_\_\_\_\_\_\_\_\_

Discharge date

Discharge status

Progress reports

Admit date

This authorization is valid for 1 year from the date provided below or **\_\_\_\_\_\_\_\_\_\_\_**, whichever is earlier. I may cancel this authorization by signing, dating, and writing “CANCEL” on this original form, by sending a written, signed and dated request to the counselor above indicating my desire to cancel or verbally informing him of my desire to rescind this release. I understand that once my information has been released, the recipient might re-disclose it, my counselor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

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##### Client’s Name Date of Birth

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##### Client’s Signature Today’s Date

Larry Epstein Mental Health PLLC

**302 Willis Avenue**

**Mineola NY 11553**

**(O)516-325-5617 (F)516-741-8456**

### Release of Information for an Emergency contact

I hereby authorize Larry Epstein LMHC CASAC to exchange information with:

Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information requested or authorized for release or exchange pertains to:

* Emergency contact

Confirm appointments

Toxicology results

Progress of Treatment/counseling

Answer drug/alcohol abuse questions

Admit date

Discharge date

Discharge status

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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##### Client’s Name Date of Birth

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##### Client’s Signature Today’s Date