**State of Iowa**
**Department of Education**
**Iowa Vocational Rehabilitation Services**

RE: _____ _____
**NAME** (Typed or Printed) **DATE OF BIRTH** and/or **SS#/OTHER IDENTIFIER**

# AUTHORITY FOR RELEASE OF INFORMATION

To: I, the undersigned, hereby authorize you to disclose and deliver to:

| | |
|---|---|
| | |

**APPROXIMATE DATE(S) OF REPORT(S):**

**THE FOLLOWING SPECIFIC INFORMATION:**

☐ Medical: Diagnosis(es), Evaluations, and Treatment Records
☐ Hospital: Admission Records, Consultant Exams, and Discharge Summaries
☐ Psychiatric: DSM Diagnosis(es), Evaluations, Treatment Records, Clinical Notes, and Discharge Summaries
☐ Psychological: DSM Diagnosis(es), Evaluations, Treatment Records, Clinical Notes, and Discharge Summaries
☐ Transcript of Grades, Performance Reports, Test Results, and IEPs
☐ Other _____

I understand that the information you release will be used as appropriate and necessary in the determination of eligibility for, and the development of a program of rehabilitation services; or

☐ Other _____

I understand that the information may be given verbally or in written form and this release includes permission to furnish IVRS copies. This form will be kept in my VR casefile and I understand that I may review the disclosed information by contacting the person, agency, or entity releasing the information. I understand that the information will be used for purposes relating to my rehabilitation programming, and will not be released to any other person, agency, or entity for any purpose without my written permission except as required by Federal or State Law. Disclosure of this information carries with it the potential for unauthorized re-disclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that any action on my part to deny access to information that is essential to my rehabilitation programming may result in delaying or stopping rehabilitation services. I also understand that I may withdraw this permission at any time by sending written notice to Iowa Vocational Rehabilitation Services, 510 East 12th Street, Des Moines, Iowa 50319. If I withdraw my permission, I understand that the withdrawal does not apply to information already received by IVRS prior to my written withdrawal. In the absence of any withdrawal or special instructions below, ***this release will automatically expire 12 months from the date of my signature***.

Restrictions and/or Comments: _____

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:**
**If information of the following types is available I give permission for its release:**
**(Client must check appropriate box[es])**

| | YES | NO |
|---|---|---|
| **1.** SUBSTANCE ABUSE | ☐ | ☐ |
| **2.** MENTAL HEALTH | ☐ | ☐ |
| **3.** HIV-RELEATED INFORMATION | ☐ | ☐ |

_____ _____
**CLIENT SIGNATURE** **DATE**

_____
STREET/P.O. BOX

_____
CITY/STATE/ZIP

_____
CLIENT SIGNATURE DATE

_____
PARENT/GUARDIAN IF CLIENT IS A MINOR/WARD DATE

_____
PARENT/GUARDIAN ***IF*** CLIENT IS A MINOR/WARD DATE

_____
WITNESS SIGNATURE DATE

_____
WITNESS SIGNATURE DATE

In order for the above information to be released, you must sign here AND to the right.

For Responding Agency Use Only: _____ Staff Initial _____ Date Released _____ Date Copy Sent to Client