

Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR)

Authorization to Release / Obtain Information

(Please read instructions on page two before completing this form.)

VR-22 (3/12)

CONSUMER NAME	CONSUMER ID NUMBER
CONSUMER ADDRESS [include street (apartment number or building, if applicable), city, state, zip]	
Adult Career & Continuing Education Services-Vocational Rehabilitation (ACCES-VR) has my permission to release or obtain information indicated in item #1 below. This information may include reports about my physical or mental condition, school records, facts necessary to determine my financial need, or other information that ACCES-VR needs to determine my eligibility and to provide vocational rehabilitation services. I understand that this information will be treated as confidential and privileged and will only be used for the purpose of obtaining services offered through ACCES-VR. I can change my mind about this release, by telling ACCES-VR in writing that I do not want any further information to be given out. I understand that information disclosed according to this consent may be subject to redisclosure and will no longer be subject to the HIPPA privacy requirements. This will not affect actions already taken with my permission. My permission to release or obtain information expires on date _____ or no later than one year from the date of signature, whichever is sooner. 1. What information is to be released or obtained? <i>(Be specific.)</i> Personal, Employment, Academic, Medical, Substance / Alcohol Abuse, Legal and Mental Health Information. 2. Who is releasing this information? <i>(Insert the full name of this person or organization.)</i> ACCES-VR, Counselor: Tracy James-Lewis 3. Who is receiving this information? <i>(Insert complete information about this person.)</i> Name: _____ Title: _____ Address: _____ 4. Why is this information needed? _____	

I have read all of the information on this form. I understand and agree to what it says.

Consumer or Parent/Guardian Signature: _____ Date: _____

This release meets all requirements of Title 45 section 164.508 of the Code of Federal Regulations, which implements HIPPA; Title 34 Part 99 of the Code of Federal Regulations, which implements the Family Education Rights and Privacy Act; and Title 42 Part 2 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse records. Form VES-540, *Prohibition on Redisclosure of Information Concerning Individuals with a Disability of Alcoholism or Substance Abuse*, must be attached to this form when necessary.

The State Education Department does not discriminate on the basis of age, color, religion, creed, disability, marital status, veteran status, national origin, race, gender, genetic predisposition or carrier status, or sexual orientation in its educational programs, services and activities. Inquiries concerning this policy of nondiscrimination should be directed to the Department's Office for Diversity, Ethics and Access, Room 530, State Education Building, Albany, NY

Authorization to Release / Obtain Information

Instructions

This *Authorization to Release / Obtain Information* form is to be used when information is to be released by or is to be requested by ACCES-VR. All such information will be treated as confidential and privileged and used only for the purposes of ACCES-VR services. Information ACCES-VR may have in the records, but obtained via a release from another provider, may be restricted from further dissemination.

If at any time the consumer wishes to terminate this release, he/she may do so by writing to ACCES-VR. Withdrawal of permission to release/obtain confidential information will not retroactively cover any information that has already been released or obtained.

You must: Sign only****

You will complete it when you have your one to one appointment.

- be as specific and precise as possible;
- not leave any questions unanswered;
- include a specific date on which the permission will end;
- include names of persons and titles or organization name receiving or sending information; and
- mark the VES-22 as void If the consumer rescinds his/her permission in writing to release/obtain further information.

Box #1: State the exact information that will be released/obtained (e.g., Medical Evaluation by Dr. Diaz dated 1/16/94; Educational Summary dated 10/5/95 from John Jay High School).

Box #2: State the name and title (if known) of the person releasing the information (e.g., Ms. Jean Jones, Vocational Rehabilitation Counselor; Dr. Browne, School Psychologist).

Box #3: Complete the name, title, and address of the person receiving the information. If an ACCES-VR counselor is sending the same document to several sources (e.g., a general medical report to a medical specialist and to an intake worker at a facility), multiple names, addresses, and titles can be filled in this box. It is not sufficient to indicate the report will be sent to a facility or program. ***A specific individual must be indicated***, so that individual becomes responsible for the confidential information.

Box #4: Provide a brief summary that indicates why the information is needed.

The consumer or parent/guardian must sign and date the form at the bottom. This date sets the timeframe for which information may be exchanged under this release form. If a different expiration date is to be established this must be indicated on the form.

LEAVE THE LAST PAGE BLANK