DVR-15a (5/01)

WORKFORCE DEVELOPMENT CABINET
DEPARTMENT OF VOCATIONAL REHABILITATION

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION FROM ANOTHER AGENCY

TO:

_____

_____

_____

_____

RE:

_____
(Name)

_____ _____
(SS#) (Birth date)

_____

_____

----------fold line----------

The above-named individual has applied for services with the KY Department of Vocational Rehabilitation and is giving informed written consent for the release of the following documents:

_____

_____

_____

This information shall be held confidential and shall be used only in the administration of the rehabilitation program of the involved individual. Personal information that has been obtained by the Department of Vocational Rehabilitation from another agency or organization may be released only under the conditions established by the other agency or organization.

_____ (Typed or printed name of Counselor)
Department of Vocational Rehabilitation

_____
DVR Counselor Signature

I have been informed of the above request and hereby authorize the release of said personal information to the Department of Vocational Rehabilitation. This authorization shall expire 60 days from the date of my signature below:

_____ _____
Signature of Individual Referenced Above Date

_____ _____
Signature of Parent or Guardian Date