DVR 15b (Rev. 4/96)

Cabinet for Workforce Development
Department of Vocational Rehabilitation

Written Consent for Release of Personal Information
In Possession of the Department of Vocational Rehabilitation

Name of Individual _____ SSN _____

Address _____

I hereby give my informed consent for the release of the following documents in possession of the Kentucky Department of Vocational Rehabilitation that contain personal information about me:

_____

_____

_____

This information may be released only to: _____

_____

who shall use it only for the following purpose: _____

_____

I understand that written medical, psychological, or other information which the Department of Vocational Rehabilitation believes may be harmful to me may not be released directly to me but will be provided through a representative, a physician, or a licensed or certified psychologist.

I understand that personal information that has been obtained by the Department of Vocational Rehabilitation from another agency or organization may be released only by or under conditions established by the other agency or organization.

This consent for release of personal information will expire 60 days from the date of my signature below:

Signature _____ Date _____

PROHIBITION ON REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IF HELD BY ANOTHER PARTY IS NOT SUFFICIENT FOR THIS PURPOSE.