# Department of Human Services/ Disabilities & Vocational Rehabilitation Services

## Authorization to Release Information

**I,**_____ hereby authorize the release / request of the following information for the purposes of provision of vocational rehabilitation services.

**Staff Person requesting information:**

_____ Name

_____ Title

_____ Address

_____ Telephone/ Fax

**Specific Nature of Information to be released *I* requested & purpose:**

_____

_____

_____

_____

**Agency Staff releasing / receiving information:**

_____ Name

_____ Title

_____ Address

_____ Telephone / Fax

I recognize that I may revoke authorization upon written notice (except to the extent that material has already been obtained or released based on the authorization) and that such authorization shall automatically expire one year from the date I signed this form unless otherwise indicated below.

_____

**Expiration date**

**I certify that I have read the statement above and that I agree to its content**

_____ Participant Signature

_____ Date

_____ Legal Guardian (if applicable)

_____ Date