IVRS Use Only:
Date Sent: _____
Sent by: _____
Staff Initials: _____

State of Iowa
Iowa Workforce Development
IOWA VOCATIONAL REHABILITATION SERVICES

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

AUTHORITY FOR RELEASE OF INFORMATION

I, the undersigned, hereby authorize and agree to disclosure of information between the two parties listed below:

The following specific information covering the approximate date(s) of report(s): _____

- ❑ 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 _____

The information shared between the parties listed above 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 IVRS case record 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 redisclosure 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:

I understand that information may be released electronically, and may include information in the following categories unless I specifically deny the release **(initial any category not to be released)**.

Substance Abuse _____ Mental Health _____ HIV-Related Information _____

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

_____ _____
DATE OF CLIENT SIGNATURE DATE OF PARENT/GUARDIAN SIGNATURE

_____ _____
STREET/P.O. BOX WITNESS SIGNATURE, IF REQUIRED BY STATE LAW

_____ _____
CITY/STATE/ZIP DATE OF WITNESS SIGNATURE

For Responding Agency Use Only:

_____Staff Initials _____Date Released _____Date Copy Sent to Client