

# Virginia Department for Aging and Rehabilitative Services Division of Rehabilitative Services

## Authorization for the Release of Personal Information

Authorization to (Name and address)

Mail to (Custodian of information)

FAX:

Client full name (Print) \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_ SSN (Optional) \_\_\_\_\_

I authorize the following information (Specify, such as "criminal record," "school records for current year," etc.):

Be released to my Virginia Department for Aging and Rehabilitative Services, Division of Rehabilitative Services (DRS) Vocational Rehabilitation (VR) counselor, or successor

Be released to the following entity(ies) or individual(s), or successor

(Name, Title, Org.) \_\_\_\_\_

By the following means (Check all that apply): Written  Orally  Electronically

This consent includes information placed in my records after the signature date: Yes  No

I understand that my records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in law or regulations. I understand that **this consent does not cover the release of protected health information or drug/alcohol diagnosis or treatment information.** I understand that if I am 18 years or older and am not under a legal guardianship, my parents/guardians cannot have access to my case information, discuss my case, or make decisions regarding my case without my written consent. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance of a signed form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Date or condition upon which this consent expires \_\_\_\_\_

Relationship to consumer: Self  Custodial Parent  Legal Guardian  Power of Attorney

Witness (Print) \_\_\_\_\_ Sign \_\_\_\_\_ Date \_\_\_\_\_

*Witness is only required for consumer who is legally competent but unable to sign due to disability*

### For DRS Use When Consent is Revoked

Consent has been: Revoked in entirety  Partially revoked as follows  (Specify below):

Date revocation received \_\_\_\_\_ By: Letter  (Attach copy) Phone  In Person

Received by (Name) \_\_\_\_\_ Title \_\_\_\_\_

Office Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Complete and send a copy to the entities listed on this consent form as notification of revoked consent**