ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
Division of Vocational Rehabilitation
A proud partner of the American Job Center Network

STATE OF ALASKA
DIVISION OF VOCATIONAL REHABILITATION (DVR)

AUTHORIZATION TO RELEASE PERSONAL/CONFIDENTIAL/SENSITIVE INFORMATION

★ **Required information. These sections must be filled in.**

★ **From:** _____ _____ SSN=XXX-XX- _____
Participant's Printed Name | Date of Birth | SSN **if needed** (use only last 4 digits)

(Participant is to initial in the box of the release type(s) required.)

☐ I grant permission for you to release to the Alaska Division of Vocational Rehabilitation the following information:

☐ I grant permission for the Alaska Division of Vocational Rehabilitation to release to you the following information:

★ **To:** _____ _____
Organization's/Individual's Name | Other Identifying Information (address, phone #, title, etc.)

★ **For the Specific Purpose of:** Coordination of Care
(Determining Program Eligibility or Identifying VR Services)

PART I

(Participant is to initial in the box of the record type(s) required.)

Medical

☐ Medical Records
☐ Hospital Records

Psychiatric/Psychological

☐ Psychiatric Reports/ Evaluations
☐ Neuropsychological/ Psychological Testing

Academic

☐ School Transcripts/Grade Reports
☐ IEP/Special Education Reports

Corrections

☐ Corrections/Arrest Records
☐ Furlough/Parole/Probation Stipulations

Other Types of Information

☐ (Specify) Case management info
☐ (Specify) DVR referral, intake, case management information

Mail/ email to: Division of Vocational Rehabilitation

Fax to:

Information pertaining to: Disability and case management services
(Specify dates of treatment, medical condition(s), etc.)

PART II

Drug & Alcohol or Sensitive Information (HIV/STD status-genetic testing-DV or sexual abuse)

(Participant is to initial in the box of the record type(s) required.)

☐ Drug & Alcohol Treatment Records
☐ Discharge Summary W/Treatment Dates
☐ Assessment Results & Recommendations
☐ Domestic Violence/Sexual Abuse
☐ HIV/AIDS /STD status
☐ (Specify) _____

PROHIBITION ON REDISCLOSURE: Information requested in Part II has been disclosed from records whose confidentiality is protected by Federal Regulations (42 CFR Part 2) prohibiting any further disclosure 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. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient. *The confidentiality of all information requested with this authorization is protected by AS 23.15.190 and 34 CFR 361.38. This authorization of release also complies with 45 CFR 164.508.*

Note: This consent is subject to revocation at any time, except to the extent that the program that is to make the disclosure, has already taken action in reliance on it. If not previously revoked, this consent will automatically expire upon DVR exit date OR on:_____
Expiration Date

★ _____ Participant's Signature | _____ Date | _____ *Parent/Guardian/Conservator Signature | _____ Date

_____ ** Witness' Signature | _____ Date | _____ ** Witness' Signature | _____ Date

*** If a participant is a minor, signature of a parent or guardian is required.**
**** If unable to write his or her name, the participant should enter an "X" or other mark. Signatures of two witnesses are required.**