IOWA DEPARTMENT FOR THE BLIND
VOCATIONAL REHABILITATION SERVICES PROGRAM
AUTHORITY FOR RELEASE AND EXCHANGE OF INFORMATION

To: _____ RE: _____

_____ _____
Date of Birth and/or Other Identifier

_____

Attention: _____ _____
Approximate Date of Report(s)

I, the undersigned, hereby authorize you to disclose and deliver to:
Attn:

Iowa Department for the Blind
524 Fourth Street
Des Moines, IA 50309
Fax: 515-242-5781

the following specific information:

- ☐ Medical: Evaluation and/or Treatment Reports Including Diagnosis/Prognosis
- ☐ Hospital: Admitting History/Exam, Consultant Exam, and Discharge Summary
- ☐ Psychiatric: Discharge Summary Letters and Clinical Notes
- ☐ Psychological: Evaluation and/or Treatment Reports
- ☐ Transcript of Grades or Other Performance Report
- ☐ Other:

I understand that the information you release will be used as appropriate and necessary in the determination of eligibility for, and the development of a program of vocational rehabilitation services; or

☐ Other:

I understand that the information may be given verbally or in written form and this release includes permission to furnish copies.

I understand that the information will be used for purposes relating to my vocational rehabilitation programming under the authority of Public Law 93-112, as amended and will not be released to any other agency, individual, or organization for any other purposes without my written permission except as required by Federal or State law. I understand it is not mandatory that I provide access to information essential to my rehabilitation services program. I further understand that any action on my part to deny access to this information may result in a delay or termination of rehabilitation services.

I also understand that I may withdraw this permission at any time by sending written note to the Department for the Blind. If I do so, I know that it cannot apply to any information that has been given before the Iowa Department for the Blind has received my written withdrawal and notified the supplier named above. 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 DRUG/ALCOHOL ABUSE INFORMATION AND/OR MENTAL HEALTH INFORMATION.

I Acknowledge that data to be released <u>MAY INCLUDE</u> material that is protected by Federal law and that is applicable to <u>EITHER</u> Drug/Alcohol Abuse or Mental Health information or <u>BOTH</u>. My signature authorizes release of all such information (as specified above).

_____ _____
Client Signature Date

_____
Parent/Guardian Signature

_____ _____
Client Signature **Date**

In order for the above information to be released, you must sign here AND to the right.

_____
Witness Signature