Authorization to Obtain/Release Information
VR-21 (10/2023)

Name:	Date of Birth:	Aware ID#:
Address:		

The Office of Adult Career and Continuing Education Services – Vocational Rehabilitation (ACCES-VR) has my permission to obtain or release information from/to individuals, government agencies and other necessary entities (including the Client Assistance Program, also known as CAP),and/or employers involved with my vocational rehabilitation.
I, or my authorized representative, understand that:

- All information will be treated as confidential.
- My confidential information may be sent and received electronically.
- This information may include, but is not limited to, reports about my disability, education records, social security administration information, records related to parole or probation, documents necessary to determine my financial need, and/or other information ACCES-VR may need to determine my eligibility for services, provide me with vocational rehabilitation services, and/or refer me to other services needed to obtain or maintain my employment goals.
- The information shared or obtained will be used exclusively for the purpose of assisting me in obtaining or maintaining my employment goals.
- I can withdraw my permission at any time regarding the releasing or obtaining of information by notifying ACCES-VR in writing (Note: This will not affect actions already taken with my permission).
- ACCES-VR may need to use the information obtained from this authorization to administer the vocational rehabilitation program.
- This authorization is valid for the life of my case unless it is withdrawn.

I have read all the information in this section and understand that ACCES-VR's 102.00 Confidentiality Policy is located at http://www.acces.nysed.gov/vr/10200-confidentiality-policy.

☐ By initialing this box, I am authorizing the release of my medical records that may be part of my record.

My signature below proves my understanding, agreement, and consent to release this information.

The following information which may be released or obtained, subject to this signed authorization, is as follows:

☐ Psychological Assessment Reports	☐ Vocational Evaluation Reports	☐ Education Records
☐ My Entire Record	☐ Other:	

The purpose for this authorization is as follows:

☐ Eligibility Determination	☐ Plan Development	☐ Referral for Services
☐ Assessment	☐ Individual's Request	☐ Other:

Name and Address of Program/School Releasing this Information:
Name and Address of Person(s) to Whom this Information Will be Disclosed:

Information regarding ACCES-VR's Confidentiality Policy was clearly explained to me, and I have read all the information on this form. My signature below proves my understanding, agreement, and consent.

If not the individual, name of person signing form:	Identify the relationship of the authority signing on behalf of the individual:

_____ _____

Signature of the Individual or Authorized Representative Date

This authorization to obtain and release information was developed to comply with the provisions regarding disclosure of education, and other information under P.L. 104-191 (HIPAA); 34 CFR 361.38; 45 CFR parts 160 and 164; 42 U.S. Code Section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S Code section 1232g (FERPA); 34 CFR parts 99 and 300. This information has been disclosed from records whose confidentiality is protected by Federal Law. Federal Regulations prohibit further disclosure of this information except with the specific written consent of the person to whom it pertains.