Authorization to Obtain/Release Information (Including Alcohol/Drug Treatment and Mental Health Information and Confidential HIV/AIDS-related Information) VR-22 (12/2023)

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 and/or entities noted below, I understand that:

1. This authorization includes disclosure of information relating to alcohol and/or drug treatment, mental health treatment, and/or confidential HIV and AIDS-related information (as indicated by my initial(s) in item #8).
2. If I am authorizing the release of alcohol and/or drug treatment, mental health treatment, and/or HIV/AIDS-related information, ACCES-VR is prohibited from re-disclosing such information without my authorization unless permitted to do so under Federal or State law.
    a. I understand that I have the right to request a list of people who may receive or use my HIV/AIDS-related information without my authorization.
    b. If I experience discrimination because of the release or disclosure of HIV/AIDS related information, I may contact the New York State Division of Human Rights at (888) 392-3644, or the New York City Commission on Human Rights (if the authorization took place within the City of NY) at (212) 416-0197.
3. I have the right to revoke my authorization at any time by notifying ACCES-VR in writing. I understand that I may revoke my authorization in the future except to the extent that action may have already been taken based upon this authorization.
4. I understand that my signing of this authorization is voluntary.

5. Name and Address of Program or Entity to Release this information:

6. Name and Address of Person(s) or Entity to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. **Unless revoked by me, the specific information may be disclosed** from _____ until _____ (insert start and end date, up to one year)

For the following to be included, indicate the specific information to be disclosed and initial below.

	Information to be Disclosed	Initials
☐Records from alcohol/drug treatment Program		
☐Clinical records from mental health programs		
☐HIV/AIDS-related Information		

9. If not the individual, name of person signing form:	10. Identify the relationship of the authority signing on behalf of the individual:

All items on this form have been reviewed and approved, my questions about this form have been reviewed and agreed to and I have been provided a copy of the form.

_____ _____

Individual Signature or Authorized Representative Date

I have discussed the execution and purpose of this authorization with the individual signing above and confirm their understanding of the information to be released.

_____ _____ _____

Staff Person's Name and Title Signature Date

Please note, form VR-540, Prohibition on Redisclosure of Information Concerning Individuals with a Disability of Substance Use, must be attached to this form when ACCES-VR is releasing information pertaining to the individual's substance use records.

Prohibition on Redisclosure: Information requested has been disclosed from records whose confidentiality is protected by Federal Regulations (42 CFR Part 2) prohibiting further disclosure except with the specific written consent of the person to whom it pertains. The confidentiality of all information requested with this authorization is protected by 34 CFR 361.38. This authorization of release also complies with 45 CFR 164.508