DEPARTMENT OF WORKFORCE DEVELOPMENT
Division of Vocational Rehabilitation

CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION

Completion of this form authorizes the release of information described below. The person (record subject) whose records are released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. This form is **voluntary**, and you are not required to consent to release personal data, however DVR may need certain records before DVR services can be provided to you, including eligibility determination, Individualized Plan for Employment development or revision, and service coordination. If you need help to complete this form, ask the person who gave you the form or call DVR at 1-800-442-3477 (Voice).

Name of **Record Subject** (Person Whose Records Will be Released)

Address

City, State, Zip Code

IRIS Case Number | Date of Birth

Name and Address of **Agency or Organization I Authorize to Release Information**

Name of **Record Recipient** (To Whom Information May be Released)

Organization

Address

City, State, Zip Code

Type or extent of information to be disclosed (Initial next to records/information that you wish to be released):

	Medical Records: Including records of general health and of diagnosis or treatment of alcohol or drug abuse treatment, mental illness, or other mental impairment and HIV/AIDS treatment. Include the physician's signature and dates for diagnosis, treatment, and prognosis.
	Financial Information: Including student financial aid packages.
	Media & Promotion: Including photographic images, recordings, interviews, case information for media or promotional use, etc.
	DVR Documents: Please specify (IPE, case notes, etc.).

	Educational Records: Please specify (IEP, transcripts, school psychologist's report documenting impairment, etc.).
	Employment Records: Including job development/placement records, job applications, resumes, wage documentation, references, etc.
	Psychological Testing: Including vocational evaluations.
	Other Records: Please specify.

I authorize DVR to communicate verbally and in writing with the party noted above related to the Record Subject's DVR case.

☐ Yes ☐ No ☐ Yes, with exceptions (specify):

My signature is authorization for release of the records specified above. I understand that I may revoke this authorization, in writing, at any time except to the extent that information was released as a result of this authorization. Unless revoked, this authorization remains in effect until the time stated below. No further release of these records is authorized without my informed written consent except as provided by 34 CFR 361.38 and Ch. DWD 68 Wis. Admin. Code. If no expiration date is specified, the authorization expires one year after the date it was signed.

A photocopy, fax, or email copy of this Authorization for Disclosure of Confidential Information is as valid as an original.

Choose One:

☐ Authorization expires as of (date).

☐ Authorization expires after the following action takes place:

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(ies) specified above.

SIGNATURE - Person Whose Records Will be Released (Record Subject) | Date Signed

SIGNATURE - Other Person Legally Authorized to Consent to Disclosure | Title or Relationship to Record Subject | Date Signed

RETAIN COMPLETED FORM IN CASE RECORD