

**CONFIDENTIAL INFORMATION
RELEASE AUTHORIZATION (SVRI)**

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**

Record Recipient (To Whom Information May be Released)
MAIL:
Stout Vocational Rehabilitation Institute (SVRI)
University of Wisconsin-Stout
221 10th Avenue East, Room 201
Menomonie, WI 54751
FAX: (715) 232-1323 (Primary) or
(715) 232-5659 (Backup)

Send invoices to the Division of Vocational Rehabilitation (DVR)	By EMAIL to: dvrvendorinv@dwd.wisconsin.gov (preferred method)	Or by MAIL to: DVR Center for Consumer Payments (CCP)	201 E Washington Ave G400 P.O. Box 7852 Madison, WI 53707
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Type or extent of information to be disclosed (Initial next to records/information that you wish to be released):

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