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WABANAKI VOCATIONAL REHABILITATION PROGRAM

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

This information will be used to assist Wabanaki Vocational Rehabilitation Program (WVRP) staff in determining eligibility and/or in planning for Vocational Rehabilitation services for:

NAME: ______________________________ DOB: ___ / ___ / ____
(Client's Name)

I authorize Wabanaki Vocational Rehabilitation Program ☐

(Vocational Rehabilitation Counselor's Name) ______________________________

Address: ______________________________

☐ to receive my information from: ______________________________
(Hospital/Doctor/Therapist/Counselor/Other's Name)

Wabanaki Health & Wellness	P.O.Box 1356	Bangor, ME 04402-0411			(207) 992-0411
(Agency)	(Street)	(City)	(State)	(Zip)	(Telephone)

Or

☐ to give my information to: ______________________________
(Hospital/Doctor/Therapist/Counselor/Other's Name)

Wabanaki Health & Wellness	P.O. Box 1356	Bangor, ME 04402-0411			(207) 922-0411
(Agency)	(Street)	(City)	(State)	(Zip)	(Telephone)

I authorize the following information to be released to the above entity: **(Please check appropriate information)**

- ☐ General Health Information
- ☐ Medical Specialist Reports
- ☐ Substance Abuse Evaluations
- ☐ Educational/School Records
- ☐ Medical/Psychiatric Hospital Records
- ☐ Psychiatric Progress Notes
- ☐ Psychiatric/ Psychological Evaluations (Diagnosis/Axis Codes)
- ☐ Psychiatric/Psychological Comprehensive Assessments
- ☐ On Going Written & Verbal Information Exchange
- ☐ Occupational /Physical Therapy Evaluation
- ☐ Vocational Assessments and Plans
- ☐ Other (Specify) ______________________________

****** PLEASE SPECIFY APPLICABLE DATES AND OTHER INFORMATION******

This release is for the period from: ____________ to ____________

I understand that:

- **I can refuse to give some or all of the information in my treatment records and also understand this could delay or cause denial of services.**
- **At any time, I can cancel all or part of this authorization by notifying my counselor named above, except to the extent that WVRP has already acted on it**
- **I am entitled to a copy of this release.**

- WVRP will not release any information about my disability to any other agency or person without the specific written consent of the individual.
- WVRP may release information without my specific consent if I pose a direct threat to others or myself. WVRP may release information without my specific consent, if required by State or Federal law; in response to an investigation in connection with law enforcement; and in response to a court order.
- WVRP may release information without my specific consent, for program audit, evaluation, or research purposes. The final product will not reveal any personal identifying information.
- This release is effective for no more than one year from date of signing.

(Consumer Initials) ________ Date ___________

State and Federal Law requires my specific consent to disclose any of the following information:
Check one response for each of the statements below:

☐ I DO ☐ I DO NOT	**Authorize disclosure of information, which refers to treatment or diagnosis of drugs or alcohol abuse. If I authorize the release of such information, I understand it cannot be re -disclosed WVRP without specific consent.**
☐ I DO ☐ I DO NOT	**Authorize disclosure of information, which refers to treatment or diagnosis of mental illness.**
☐ I DO ☐ I DO NOT	**Wish to review this information before it is released. I understand any such review must be supervised.**
☐ I DO ☐ I DO NOT	**Authorize disclosure of information, which refers to treatment or diagnosis of HIV infection, ARCS, or AIDS. I understand that individuals about whom such disclosures have been made encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships.**

Verbal Authorization to Obtain/Release Information

Name of Client/legal guardian Providing verbal authorization and consent to release information:______________________
Date of verbal authorization:____________

Verbal authorization valid only with two witness signatures. Witness signatures below verify both parties were in direct verbal communication with client/legal guardian to confirm his/her authorization and consent to release information as indicated on this form. Client/legal guardian required to sign this form as indicated below at next scheduled appointment or within 2 weeks of verbal authorization.

______________________________ ______________________________
Witness Signature Date Witness Signature Date

Signature: ____ Date: __________

Parent/Guardian: ____________________________ ________________ Date __________
Relationship

Witnessed by: ____ Date __________

THIS RELEASE MUST BE FILLED OUT COMPLETELY.
PLEASE READ CAREFULLY. IF YOU HAVE QUESTIONS,
PLEASE ASK YOUR COUNSELOR.