Montana Vocational Rehabilitation Programs (MVR)
Montana Department of Public Health & Human Services

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

Once the information is disclosed, it may be subject to re-disclosure by the recipient and federal privacy laws or regulations may no longer protect the information. I can cancel permission to use and disclose my information at any time in writing. Permission to use and disclose alcohol and drug treatment records can be canceled by talking with my counselor. My refusal to sign this release may impact the provision of MVR services and my counselor will inform me of the impact should I choose not to sign.

To:
____
____
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Return to:
Montana Vocational Rehabilitation/Pre-ETS

Counselor Name: ________________________________

Phone Number: ________________________________

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Consumer:______________________________ ***Birth Date:***____________________________________

Maiden or Other Name:____________________ ***Social Security Number:***________________________

☐ I request and authorize to release to Montana Vocational Rehabilitation the specified information.
☐ I authorize Montana Vocational Rehabilitation to release to you the specified information.

The specified expiration date for this release of information is:________________________________.
(The expiration date may not exceed 30 months from the date of signature. The expiration date is 6 months from signature if this field is left blank.)

Explanation / Purpose: ____

Information To Be Released: (P*lease initial that information you wish released.)*

______Academic Information
______Chemical Dependency Assessment/Treatment
______Employment Information
______Financial Information
______Medical Records
______Psychiatric Evaluation/Treatment
______Psychological Evaluation/Treatment
______Social Security
______Work Evaluation
______Other ________________________

____ ________________________
Consumer Signature / Approval Date

____ ________________________
*Parent or Guardian Signature / Approval Date

____ ________________________
**Witness Signature Date

____ ________________________
**Witness Signature Date

* If consumer is a minor, signature of a parent or guardian is required.
** If unable to write his or her name, the consumer should enter an "x" or other mark. Signatures of two witnesses are required.

I request this authorization to release personal information be revoked.

Signature:____ ***Date:***__________________

Vocational Rehabilitation is a HIPAA compliant Program of Department of Public Health and Human Services.