N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
VOCATIONAL REHABILITATION

AUTHORIZATION TO DISCLOSE VOCATIONAL REHABILITATION INFORMATION INSTRUCTIONS

PURPOSE

To assist the Vocational Rehabilitation (VR)/Independent Living Rehabilitation (ILR) Counselor in obtaining VR confidential information from pertinent sources identified by the individual that will assist in providing rehabilitation services to the extent that the individual is successful in reaching the vocational goal of employment and self sufficiency.

PREPARED BY

Vocational Rehabilitation/ Independent Living Rehabilitation Counselor

INSTRUCTIONS

Name: Enter the individual's name (first name, middle initial and last name).

Date of Birth: Enter the two-digit month, two-digit day and four-digit year.

I, _______ Enter the individual's or personal representative's name (first name, middle initial and last name).

hereby authorize: Name the entity the VR/ILR Counselor is requesting information.

to disclose specific Vocational Rehabilitation information from the records of the above-named individual to:

Enter the VR/ILR (ILR) Counselors Name (first name and last name)

Enter the specific District Office to include the most current street address, PO Box, city, state and five-digit zip code.

Phone #: Enter the specific District Office phone number to include the area code and seven-digit number and the specific District Office toll free phone number to include the area code and seven-digit number.

Fax: Enter the specific District Office fax number with area code and seven-digit number.

for specific purpose(s): Enter the specific reasons for the request.

Individual signs and date the form.
Witness signs the form.
Personal representative signs and dates the form and identifies his/her relationship and/or authority.

DISTRIBUTION

Original: Entity that information is being requested
Copies: Case Record