

STATE OF ARKANSAS



Mike Beebe  
Governor

Bill Walker  
Director

Arkansas Career Education  
Division of Rehabilitation Services  
Jonathan Bibb, Commissioner

http://www.arsinfo.org  
An Equal Opportunity Employer

Authorization for Release/Disclosure of Personal Information

Instructions to ARS staff: Original copy to information holder. Copy to recipient of information.

I authorize: (name & address of person/organization that will release the information)

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Organization: \_\_\_\_\_  
Street: \_\_\_\_\_  
Suite/Apt#: \_\_\_\_\_ Zip: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_

to release the information indicated below to:  
(name & address of person/organization to which information is to be released)

Name: \_\_\_\_\_  
Organization: \_\_\_\_\_  
Street: \_\_\_\_\_  
Suite/Apt#: \_\_\_\_\_ Zip: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_

Purpose(s) of this release (check one):

- This information is being sent or requested by ARS for purposes associated with my eligibility for the provision of vocational rehabilitation services.
- Other purpose: \_\_\_\_\_

Additional Information: \_\_\_\_\_

I also authorize shared disclosure between both parties named above for all of the information approved by this Release/Disclosure form, for purposes of coordinated planning.

Consumer name	Date of Birth	SSN# (Last 4 digits only)
Signed (Consumer)		
If minor, signature of parent or guardian; conservator, if applicable	Relationship to consumer	
<ul style="list-style-type: none"><li>• If release is not related to my obtaining ARS services, my refusal to sign will not affect my ability to receive services from ARS.</li><li>• I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by privacy regulations.</li><li>• This authorization may be revoked by me at any time by notifying ARS in writing, except to the extent that action has been taken in reliance on it. Unless expressly revoked earlier, this authorization expires as noted here (box below)</li></ul> SPECIFY DATE, EVENT, OR CONDITION		

Information Types:

Type of Information: \_\_\_\_\_

Date of Authorization: \_\_\_\_\_

Consumer's Initials: \_\_\_\_\_

Consumer name	Date of Birth	SSN# (Last 4 digits only)
Signed (Consumer)		
If minor, signature of parent or guardian; conservator, if applicable	Relationship to consumer	
<ul style="list-style-type: none"><li>• If release is not related to my obtaining ARS services, my refusal to sign will not affect my ability to receive services from ARS.</li><li>• I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by privacy regulations.</li><li>• This authorization may be revoked by me at any time by notifying ARS in writing, except to the extent that action has been taken in reliance on it. Unless expressly revoked earlier, this authorization expires as noted here (box below)</li></ul>		
SPECIFY DATE, EVENT, OR CONDITION		

**Note to Recipient of Information:**

The confidentiality of this record is required under chapter 869 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.

**\* Alcohol and/or drug treatment records:**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**\*\* HIV Related Information:**

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.