

Mark-Up

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#: _____
City: _____

Zip: _____
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#: _____
City: _____

Zip: _____
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	

- If release is not related to my obtaining ARS services, my refusal to sign will not affect my ability to receive services from ARS.
- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by privacy regulations.
- 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)

SPECIFY DATE, EVENT, OR CONDITION

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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">• If release is not related to my obtaining ARS services, my refusal to sign will not affect my ability to receive services from ARS.• I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by privacy regulations.• 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) <p>SPECIFY DATE, EVENT, OR CONDITION</p>		

Note to Recipient of Information:

The confidentiality of this record is required under chapter 899 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.