OVR - 132
4/15
ALL

Reset Form | Print Form

Department of Labor & Industry
Office of Vocational Rehabilitation

CUSTOMER AUTHORIZATION FOR THE DISCLOSURE OF RECORDS TO THE OFFICE OF VOCATIONAL REHABILITATION

Name: _____ Social Security No.: _____

OR

To: _____ DOB: _____

For the time period of _____ to _____

I am requesting services from the Office of Vocational Rehabilitation (OVR). In order to facilitate the provision of vocational rehabilitation services, I hereby authorize you to release the following records to OVR:

THE SPECIFIC INFORMATION TO BE DISCLOSED IS:

- ☐ Out patient and in patient records
- ☐ Presence in treatment/attendance
- ☐ Assessment, history, diagnosis, recommendation
- ☐ Psychiatric/Psychological/Psychosocial history and evaluation
- ☐ Medication and psychiatric records
- ☐ Progress in treatment/progress notes
- ☐ Discharge Summary and plans
- ☐ HIV/AIDS records
- ☐ Other, specify: _____

THE PURPOSE FOR DISCLOSURE IS:

- ☐ Diagnostic Services
- ☐ Determination of eligibility
- ☐ Service Delivery by OVR
- ☐ Other, specify: _____

I release the above entity that disclosed this information from any legal responsibility or liability for disclosure of the above information to the extent that the information was used for its stated purposes.

Information used or disclosed pursuant to this authorization may no longer be protected by the Health Insurance Portability and Accountability Act. I understand that my records are protected under 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2, 71 P.S. 1690.108, 28 PA Code § 709.28 and 4 PA. Code § 255.5 governing the Confidentiality of Alcohol and Drug Abuse Patient Records. I further understand that my records are protected by the Confidentiality of HIV Related Information Act, 35 P.S. § 7601, et. seq. I further understand that OVR shall only disclose this information pursuant to the guidelines set forth in 34 C.F.R. 361.38 and in OVR's policies.

This authorization or a photostatic copy of this authorization shall be considered valid until withdrawn in writing by my personal representative or me. Unless otherwise revoked, this authorization is valid for one year after the date of either my signature or my personal representative's signature.

I certify that I fully understand this authorization.

☐ If necessary to accommodate my needs, an alternative format of this authorization has been provided to me.

_____ _____
Customer's Signature Date

Counselor/Social Worker: _____ Date: _____

_____ _____
Personal Representative's Signature (if applicable) Date

Description of Personal Representative's Authority to Act for the Customer:

☐ Verbal response given (Customer physically unable to give written consent)

A verbal consent requires two (2) witness signatures. I witness that Customer (or responsible person) is definitely unable to provide a signature at this time, but understands the nature of the release and freely gives his/her consent.

_____ _____
Witness Date

_____ _____
Witness Date

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program