AUTHORIZATION FOR RELEASE OF INFORMATION

To:_____

_____

_____

RETURN TO:
Warm Springs Vocational Rehabilitation Program
PO Box C
Warm Springs, OR 97761
Attention:_____

_____ I hereby request and authorize you to release to the Warm Springs Tribal Vocational Rehabilitation Program the following information that you have pertaining to me.

_____ I hereby request and authorize the Warm Springs Tribal Vocational Rehabilitation to release to you the following types of information which it has pertaining to me.

THIS CONSENT TO WRITTEN REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN THEREON

Information	Date of Consumer Authorization	Consumer Initials	Information	Date of Consumer Authorization	Consumer Initials
School Transcripts			Native Blood Quantum		
Other Academic Information			Employment Records		
Psychological Testing			Financial Information		
Psychological Evaluations			Oregon State Service Vocational Rehabilitation		
Medical Records/Reports			Substance Abuse Treatment Program		
Hospital Records			Other (specify):		

(Optional): b

THIS RELEASE OF INFORMATION WILL EXPIRE WITHOUT EXPRESS REVOCATION ON_____
(Give specific date) Consumers Initial:_____

_____
Consumers Full Name (Printed)

_____
Consumers Social Security Number

_____
Consumers Date of Birth

_____
Consumers Signature

_____
Date Signed

_____
Parent or Guardian Full Name (Printed)

_____
Parent or Guardian Signature

_____
Witness Signature

_____
Vocational Rehabilitation Counselor Signature

_____
Date Signed

* If Consumer is a minor, the Signature of a parent or guardian is required.
** If unable to write his/her name, consumer should enter an "X" or other mark; the signatures of two witnesses are required

I understand that my records are protected under Federal Confidentiality Regulations (42 CFR, part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations.