



Release of Information

02/2024

Releasing and Obtaining Information. In general, Nebraska VR will only release information about me according to my written consent below. However, VR will release information *without my consent*, according to federal regulations, in response to a court order, or if a law, the need to protect me or others, or an investigation for law enforcement, fraud, or abuse requires release. VR will only use this release to obtain information that is necessary and relevant to my vocational rehabilitation process.

Organizations and Individuals. VR has permission to exchange (release and receive) information about me with the following organizations or individuals:

- | | |
|---|---|
| Client Assistance Program | Third Party Employment and Income Verification |
| Employers (past, current, prospective) | Veterans Administration |
| Disability Determinations Section | Secondary schools _____ |
| Nebraska Department of Correctional Services | Assistive Technology Partnership (ATP) |
| Nebraska Board of Parole/Probation Supervision | NE Department of Health and Human Services |
| Social Security Administration | Educational Service Units |
| Post-secondary institutions _____ | Career Pathway Advancement Project (CPAP) |
| Nebraska Worker's Compensation Court | Others (including family members): |
| Employment Networks | _____ |
| Nebraska Workforce Development System | Student Financial Aid and Disability Services Offices at |
| Physicians, psychologists, licensed medical providers hospitals | _____ |
| or treatment centers that have treated or will treat me: | Community Rehabilitation Programs, Centers for Independent Living or |
| _____ | other entities or persons that provide or will provide services to me |
| _____ | under a written agreement with VR: |
| _____ | _____ |
| _____ | _____ |

List any programs or persons you do not want us to share information with.

Types of Information. VR has permission to exchange (release and receive) the following information about me:

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| Information on my Application | Drug or alcohol treatment records (including AIDS/HIV) |
| Vocational tests, assessment scores and/or analysis | Information about receipt of public or private benefits |
| Medical or psychological records including narrative reports | Hospital exams and summaries |
| School grades, transcripts, test results, progress reports, _ | Training information |
| Safety Plan, Behavioral Intervention Plan, and | Employment information and records |
| Functional Behavioral Assessment | Psychological testing records including psychometric test scores |
| Information about my service goals, services provided, | Verification of work hours, earnings/benefits |
| progress, and eligibility for financial aid | Other information: _____ |
| School Multidisciplinary Evaluation Team verification and | _____ |
| individual education program (IEP) records | _____ |

List any types of information you do not want us to share.

Consent to Release and Exchange Information: I authorize the use of this Information Release, or a photocopy or fax of it, to obtain information and to release or exchange the information listed from organizations, agencies, entities or persons listed. I understand I may revoke all or part of this consent at any time by providing a written notice to VR. In any event, my authorization will end on the day I cease to be an applicant for, or recipient of, services from Nebraska VR. I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations except for federal and state privacy laws and regulations concerning release of personal information of applicants for and eligible individuals receiving rehabilitation services. I understand if I am on the Nebraska Sex Offender Registry this information will be disclosed by VR to potential employers for the purpose of obtaining suitable employment. I understand that if the information in my health record includes information relating to behavioral or mental health services, treatment for alcohol and/or drug abuse, sexually transmitted disease, Hepatitis B or C testing, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), I agree to its release.

Individual (Print Name)	Date of Birth	Social Security Number X X X - X X -
Individual (Signature) X		Date
Authorized Representative (Signature) X		Date