

## AUTHORIZATION FOR RELEASE OF RSA RECORDS (Including HIPAA Covered Records)

I, the undersigned individual or legal representative, hereby authorize the Rehabilitation Services Administration (RSA) to use or disclose confidential client information regarding:

Name \_\_\_\_\_

Also Known As (AKA) / Maiden Name \_\_\_\_\_

Address (No., Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Authorization Expiration Date \_\_\_\_\_ Phone Number \_\_\_\_\_

The information may be disclosed to and used by the following:

Name: \_\_\_\_\_ Attention: \_\_\_\_\_

Address (No., Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Requested Method of Delivery:  Mail  Verbal  Pick-up  Email  Fax

Email Address \_\_\_\_\_ Relationship to RSA Client Parent

The date(s) of service and the type(s) of information to be used or disclosed are as follows:

RSA Case Notes  
\_\_\_\_\_

Medical Records  
\_\_\_\_\_

Functional Capacity Evaluation  
\_\_\_\_\_

Vocational Evaluation  
\_\_\_\_\_

Vendor Progress Notes  
\_\_\_\_\_

Psychological / Neuropsychological Evaluation  
\_\_\_\_\_

Other  
Allow parents to receive copies of VR forms, letters, & documentation via email or mail regarding client  
\_\_\_\_\_

Other  
Progress/updates with VR counselor. Verbal/email/mail communications regarding participation in program.  
\_\_\_\_\_

All RSA Records  
\_\_\_\_\_

**The purpose of this disclosure or use is:**

To participate in ongoing VR meetings and provide input on service delivery. Notifications of meeting and appointments.

- Controlling federal and state statutes limit RSA release of confidential client information. I understand by signing this release I authorize release of my confidential information to the named recipient.
- RSA may be in possession of secondary source information that is prohibited from re-release. This information may be requested from the original source through the client.
- Reports and evaluations generated by RSA are intended for the sole purpose of planning and administering an individualized rehabilitation program.
- RSA will not accept liability for the use of this information in any other manner than intended and authorized by the client.
- Confidential client information may not be used by the recipient for purposes not stated in this authorization.
- The recipient may not release confidential client information to others.
- If no expiration date or condition is specified, this authorization shall expire one year from the date of this authorization.
- I understand that except to the extent that the disclosure authorized has been acted upon prior to the receipt of any revocation I may revoke this authorization at any time by written notice to RSA.
- I understand that I may have a copy of this signed authorization if I request it.
- The parent or legal guardian must sign this authorization if the RSA applicant/client is a minor (under age 18) or has a legal guardian.

RSA Applicant/Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Legal Representative's Signature \_\_\_\_\_ Date \_\_\_\_\_

If signed by the Legal Representative, indicate your relationship to the individual and provide appropriate documentation to verify your authority.

Parent     Guardian     Power of Attorney     Other: \_\_\_\_\_

A copy of this completed, signed and dated form must be given to the Legal Representative on behalf of the individual.

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Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, call 1-800-563-1221; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local.