OVR 15A

(Rev. 02/2026)

Kentucky Office of Vocational Rehabilitation
Request for Records

Kentucky Career Center
Vocational Rehabilitation

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

INDIVIDUAL INFORMATION

First Name	Middle Initial	Last Name

Date of Birth *(mm/dd/yyyy)*	SSN (Last four digits)	Case Number (6 digits)

As the above-named individual, or authorized representative of named individual, I hereby authorize the disclosing party named below (Disclosing Party) to disclose the following health information to the Kentucky Office of Vocational Rehabilitation (Receiving Party) for the purpose of determining eligibility for and/or the nature and scope of vocational rehabilitation services:

All of my information covering the period from to

Specific Records to be Disclosed:

- Alcohol/Drug Abuse Treatment
- Audiological Records
- Ophthalmological Records
- Core Partner Records
- Educational Records
- HIV/AIDS testing, diagnosis treatment
- Medical Records
- Mental Health Records
- Other

If other, please specify:

Specific Information in the records to be disclosed (i.e., Diagnosis, Prognosis, Treatment Summary/Compliance, Test Results, Recommendations, Permanent Restrictions/Functional Limitations, Medication)

DISCLOSING PARTY

Disclosing Party		
Address Line 1		
Address Line 2		
City	**State**	**Zip Code**

RECEIVING PARTY (KENTUCKY OFFICE OF VOCATIONAL REHABILITATION)

The personal or protected health information pertaining to my selections on this form, shall be disclosed to the Kentucky Office of Vocational Rehabilitation for the purpose of determining eligibility for and/or the nature and scope of vocational rehabilitation services:

Counselor's First Name	Middle Initial	Last Name
Address Line 1		
Address Line 2		
City	**State**	**Zip Code**
Email Address	**Phone Number**	**Fax Number**

MY RIGHTS

I. I understand that treatment, payment, enrollment, or eligibility for benefits from the above-named disclosing party may not be conditioned upon my signing of this authorization and that I have the right to refuse to sign this authorization. However, the receiving party may require the requested information in making its determination of eligibility and benefits under the Rehabilitation Act of 1973 as amended (P.L. 113-128)

II. I may revoke this consent in writing at any time provided to the Office of Vocational Rehabilitation. However, any action taken in reliance on this consent prior to receipt of the revocation cannot be reversed and my revocation does not affect those actions.

III. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by Kentucky Office of Vocational Rehabilitation and is no longer protected by the HIPAA Privacy Standards.

IV. Information disclosed to the Office of Vocational Rehabilitation shall be held confidential and shall be used only in the administration of the vocational rehabilitation program of the identified individual. Personal or protected health information that has been obtained by the Office of Vocational Rehabilitation from another agency or organization may be released only under the conditions established by that agency or organization.

V. I understand that I have a right to receive a copy of this authorization. A photocopied version of this authorization is as valid as the original.

VI. This authorization expires ***1 year from the date of my signature below unless revoked in writing prior to that date*.**

SIGNATURES

individual Signature Date

Witness Signature Date

Parent/Guardian/Power of Attorney Signature Date

If the individual is a minor, has a court appointed legal guardian, or a Power of Attorney acting on the individual's behalf, please complete the following:

Guardian/Legal Status:

Parent Legal Guardian Power of Attorney

Printed Name of Parent/Legal Guardian/Power of Attorney

The Kentucky Office of Vocational Rehabilitation (KYOVR) does not discriminate on the basis of race, color, religion, sex, national origin, sexual orientation, gender identity or expression, ancestry, age, pregnancy or related medical condition, marital or familial status, disability, veteran status, political affiliation, or genetic information in accordance with state and federal laws. (Documents are Printed with Federal Funds) (Rev. Dec. 2025)