

1. INDIVIDUAL INFORMATION

First Name		Middle Initial	Last Name
SSN (last 4 digits)	Date of Birth (mm/dd/yyyy)		Case Number (6 digits)

2. CONSENT FOR RELEASE

I hereby give my informed consent to the Kentucky Office of Vocational Rehabilitation to release the following: *(select all that apply)*

- Documents
 Verbal Communications

<p>This information may include personal or protected health details about me. Please describe the nature of the personal or protected health information you are giving the agency permission to release.</p>
<p> </p>
<p>This information may be released only to:</p>
<p> </p>
<p>Who shall use it for the following purpose(s):</p>
<p> </p>

3. TERMS AND CONDITIONS

- I understand that written medical, psychological, or other information which the Office of Vocational Rehabilitation believes may be harmful to me may not be released directly to me but shall be provided through either a third party chosen by me such as, a family member, advocate, or qualified medical or mental health professional; or a court appointed representative.
- I understand that personal and protected health information that has been obtained by the Office of Vocational Rehabilitation from another agency or organization may be released only by or under conditions established by the other agency or organization.
- 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.

The following date / event / condition allows this release to expire within one (1) year from the signed date:

4. SIGNATURES



Individual Signature

Date



Parent / Legal Guardian / Power of Attorney Signature

Date

Printed Name of Parent / Legal Guardian / Power of Attorney:

Status of Parent / Legal Guardian / Power of Attorney:

Parent

Legal Guardian

Power of Attorney

PROHIBITION ON REDISCLOSURE:

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other protected health information if held by another party is not sufficient for this purpose.

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)