OVR 15A

(rev. 01/2024)

Kentucky Office of Vocational Rehabilitation
Authorization for Release of
Personal or Protected Health Information

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.

I. My Authorization

Consumer Name	Date of Birth	SSN *(last 4 digits)*

As the above-named consumer, or authorized representative of named consumer, 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

☐ Educational Records

☐ HIV/AIDS testing, diagnosis, and 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)

II. Disclosing Party

Disclosing Party		
Address		
City	**State**	**Zip Code**

III. 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:

Vocational Rehabilitation Counselor's Name		
Address		
City	**State**	**Zip Code**
Email Address	**Phone Number**	**Fax Number**

IV. 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 understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. To revoke this authorization, I must do so in writing and send it to the appropriate disclosing and receiving parties

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 photographic copy of this authorization is as valid as the original.

VI. This authorization expires ***1 year (365 days) from the date of my signature below unless revoked in writing prior to that date*.**

V. Signatures

Consumer Signature _____ Date _____

Witness Signature _____ Date _____

Representative Signature _____ Date _____

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

Authority of representative to sign on behalf of the consumer:

◯ Parent ◯ Legal Guardian ◯ Power of Attorney

Printed Name of Representative

_____