



Individual's Waiver of Statutory Confidentiality Rights

The undersigned Individual or guardian/representative of the Individual hereby WAIVES his/her confidentiality rights pursuant to Section 413.341, Florida Statutes, to the extent required to permit the Division of Vocational Rehabilitation (VR) to release information pertaining to the Individual and/or release a copy of the Individual's records, as defined in such statute, and/or testify thereon, and/or allow the below-referenced person or entity to discuss the Individual's case with VR personnel. The Individual or guardian/representative wishes to designate the below-identified person or entity to receive records and information.

By checking this box, I specifically authorize VR to also release any information from my file related to HIV/AIDS.

RECIPIENT OF INFORMATION/RECORDS

Name of the Individual or Entity to whom Information or records is to be released.

Street Address, City, State, and Zip Code

VR CUSTOMER INFORMATION

Customer's Name (Print)

Customer Social Security Number
(Last 4 digits)

Customer's or Guardian/Representative Signature

Date

LIMITATIONS: Individual's Social Security/Case Number is herein provided for identification only and shall not be further disclosed.

EXPIRATION: This WAIVER will automatically expire after case closure unless another date is specified below or a revocation is provided.

By checking this box, I am selecting an alternate expiration date for the expiration of this waiver as indicated below.

Expiration DATE: _____

NOTE: The above WAIVER pertains solely to records generated or paid for by VR. This WAIVER shall authorize VR to release the name(s) and address(es) of any third party(ies) who, solely as a courtesy, supplied their records to the VR. Such information, if desired, should be requested directly from such third party(ies). See 34 CFR § 361.38 (c)(3).