South Central WORKFORCE Investment Board

AUTHORIZATION FOR RELEASE PERSONAL INFORMATION

Client Name:		**Birth Date:**
App ID:		

I hereby authorize the South Central Workforce Investment Board (SCWIB) to use or disclose my personal information. "Personal Identifiable Information" is any information that relates to: Services I am applying for, have received or will receive through the workforce system. This includes information required to determine eligibility, provide documentation and secure funding.

What Information is to be disclosed (i.e. Medical records, Updates on service progress, Medication compliance, Probation/parole compliance):

Exploration of fees associated with attending training/school, items needed for securing employment, supportive services.

Who will these records be shared with (i.e. Parent, Medical Office, Training Provider, Service Organization (preferable to be general, such as caseworker name, probation/parole vs. PO name):

Please note, you need to complete a separate Release Form for each organization or individual that will request records.

I agree that my personal information will be used/disclosed for the following purpose(s) (i.e. Attending School/Training, Securing Employment, career planning & services)**:**

Employment and Educational services, on-going case management, and documentation of performance, including placement in employment, training/education, proof of certificates, diplomas, degree or credentials.

Related to the following time period(s): ___/___/___ to ___/___/___

The release should cover a full year, beginning with the date it is signed (the date at the bottom of this form) and ending one year in the future from that. The beginning data can go back as far as necessary, but usually it is sufficient to start with the first contact date.

I understand that I have the right to revoke this Authorization in writing, except to the extent the SCWIB has acted in reliance upon this Authorization. I understand that I may see and copy the information described on this form if I ask for it, and that I may obtain a copy of this form after I sign it. I understand that Personal Identifiable Information disclosed in reliance on this Authorization may be re-disclosed by the recipient(s) listed above and may no longer be protected by HIPAA or other potentially applicable laws affecting the privacy of information. ***I understand that this Authorization is voluntary and that I may refuse to sign this Authorization.*** My refusal to sign will not affect my ability to receive services, except in limited circumstances such as research or certain employment situations.

This Authorization expires one year from the date it is signed or if revoked in writing.

I have read and understand the above, and I agree to the terms of this Authorization.

Signature of Client

Date