



Last Name: _____ First: _____ Middle Initial: _____

Social Security Number: _____ Birthdate (m/d/yyyy): _____

Current Address: _____

* The following information is needed for the purpose of completing a background check if determined applicable:

* Maiden/Married Names (if applicable): _____ *Aliases: _____

* Driver's License or State ID number: _____

I authorize Opportunities for Ohioans with Disabilities (OOD) or one of its VR Contractors to:

obtain information about me from, and/or release information about me to:

Source Name: _____ Phone #: _____ Fax #: _____

Address: _____

I am aware that my confidential personal information may be sent and received electronically. I am authorizing that the information indicated below can be obtained or released by OOD or one of its VR Contractors.

Purpose for obtaining and/or releasing information indicated below:

- Medical Information Drug abuse, alcoholism, other substance use disorders
 Psychological/Psychiatric Records Vocational Evaluations and Reports
 Educational Records Sickle Cell Anemia
 Human Immunodeficiency Virus Infection (HIV), including Acquired Immunodeficiency Syndrome (AIDS)
 Other: Please specify: _____
 Background Information, including criminal background check, Sex Offender Registry search, and residence check using Social Security Number. For background information, please provide:

I am requesting that this consent expire:

- 12 months from the date of my signature (maximum for medical or psychological information)
 on (date)
 upon closure of my case.

❖ I understand that I may cancel this consent at any time, preferably by written request, to my OOD counselor or my VR contract coordinator.

This general and special authorization to obtain and disclose was developed to comply with the provisions regarding disclosure of medical, educational and other information under P.L. 104-191 ("HIPAA"); 34 CFR 361.38; 45 CFR parts 160 and 164; 42 U.S. Code Section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and Ohio State Law, OAC 3304-2-63. This information has been disclosed from records whose confidentiality is protected by Federal Law. Federal Regulations prohibit 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 information, if held by another party, is not sufficient for this purpose.

Individual's Signature _____

Date _____

Individual's Parent or Legal Guardian's Signature (if applicable) _____

Date _____

VR Staff or VR Contractor's Signature _____

Date _____

OOD and VR Contractors do not discriminate against any person on the basis of race, color, religion, national origin/ancestry, disability, age (40 years or older), sexual orientation, gender or sex, veteran or military status, and/or genetic information or in any manner prohibited by law.

A copy of this form shall be: 1) provided to the individual and, if applicable, his/her parent or legal guardian; 2) placed in the AWARE Case File; and 3) provided to any of the sources whom are listed above.