

Kentucky Office of Vocational Rehabilitation OVR 15B

Written Consent for Release of Personal or Protected Health Information in Possession of the Office of Vocational Rehabilitation

Name of Individual

SSN

Address

I hereby give my informed consent for the release of the following documents in possession of the Kentucky Office of Vocational Rehabilitation that contain personal and protected health information about me:

This information may be released only to:

who shall use it only for the following purpose:

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, an advocate, or qualified medical or mental health professional; or a court-appointed representative.

