KAWERAK, INC. ~ Education, Employment, and Training Division
P.O. Box 948, Nome, AK 99762 ~Web site: www.kawerak.org ~Phone (907) 443-4358 ~1-800-450-4341 ~Fax: (907) 443-4485

AUTHORIZATION OF RELEASE OF INFORMATION FORM

I do hereby authorize the mutual exchange of information regarding myself, between the Kawerak Education, Employment, and Training Services Program and the agencies or persons listed below:

Applicant Authorization To Release Information:

Client Name: _____SSN: _____Date of Birth: _____

Other Names Under Which Records Might Be Filed: _____

Address: _____Phone: _____

Address of Person or Organization Releasing Information:

1. Name: _____

Address: _____

Fax: _____ Phone: _____

Address of Person or Organization Receiving Information:

2. Name: Kawerak, Inc. Education, Employment, & Training Programs

Address: P.O. Box 948 / 504 Seppala Drive, Nome, AK 99762

Fax: (907) 443-4485 Phone: (907) 443-4358

Description of information to be released:

_____
_____
_____

The purpose of the release of this information is: At the request of the individual – Obtain information for the use in the determination of eligibility for Education, Employment, and Training services through the Kawerak Tribal Vocational Rehabilitation Program, and for exchange of information for the Employment Development Plan and career guidance services.

I hereby authorize the use or disclosure of my personal and protected information described above. I understand that this authorization is voluntary. I understand that my records may contain sensitive information. I understand that I may revoke this authorization at any time by signing the revocation section on the back of this release, or by notifying the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization. This authorization expires one year from the date of signature.

_____ _____
Signature of Applicant Date

_____
Print Name

_____ _____
Signature of College and Career Specialist Date

_____
Print Name

NOTE: This authorization will be revoked 5 years from the date of services unless otherwise services are extended mutually agreed upon.