N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
INDEPENDENT LIVING REHABILITATION

AUTHORIZATION TO DISCLOSE INDEPENDENT LIVING REHABILITATION INFORMATION INSTRUCTIONS

PURPOSE

To assist the Independent Living Rehabilitation (ILR) Counselor in obtaining ILR confidential information from pertinent sources identified by the individual that will assist in providing rehabilitation services to the extent that the individual is successful in reaching the goal of self sufficiency.

PREPARED BY

Independent Living Rehabilitation Counselor

INSTRUCTIONS

Name: Enter the individual's name (first name, middle initial and last name).

Date of Birth: Enter the two-digit month, two-digit day and four-digit year.

I, _____ Enter the individual's or personal representative's name (first name, middle initial and last name).

hereby authorize: Name the entity the ILR Counselor is requesting information.

to disclose specific Independent Rehabilitation information from the records of the above-named individual to:

Enter the ILR Counselors Name (first name and last name)

Enter the specific District Office to include the most current street address, PO Box, city, state and five-digit zip code.

Phone #: Enter the specific District Office phone number to include the area code and seven-digit number and the specific District Office toll free phone number to include the area code and seven-digit number.

Fax: Enter the specific District Office fax number with area code and seven-digit number.

for specific purpose(s): Enter the specific reasons for the request.

Individual signs and date the form.

Witness signs the form.

Personal representative signs and dates the form and identifies his/her relationship and/or authority.

DISTRIBUTION

Original: Entity that information is being requested

Copies: Case Record