

INDIVIDUAL'S WAIVER OF STATUTORY

CONFIDENTIALITY RIGHTS

The undersigned Individual or guardian representative of the Individual hereby WAIVES his/her confidentiality rights pursuant to Section 413.341, Florida Statutes, to the extent required to permit the Division of Vocational Rehabilitation (VR) to release information pertaining to the Individual and/or release a copy of the Individual's Client's or Applicant's records, as defined in such statute, and/or testify thereon, and/or allow the below-referenced person or entity to discuss the Individual's case with VR personnel. The Individual or guardian representative wishes to designate the below-identified person or entity to receive records and information.

By checking this box, I specifically authorize DVR to release any information from my file related to HIV/AIDS.

**Name of the Person or Entity to whom
information or records is to be released**

Print Individual's Name

Address

**Individual's Social Security Number (last 4
digits)**

City, State and Zip Code

Individual's Signature

Date: _____

LIMITATIONS: Individual's Social Security/Case Number is herein provided for identification only and shall not be further disclosed.

EXPIRATION: This WAIVER will automatically expire 12 months after the date signed unless another date at a later time is specified in writing or a revocation is provided.

NOTE: The above WAIVER pertains solely to records generated or paid for by VR. This WAIVER shall authorize DVR to release the name(s) and address(es) of any third party(ies) who, solely as a courtesy, supplied their records to the DVR. Such information, if desired, should be requested directly from such third party(ies). See 34 CFR § 361.38 (c)(3).