

Shoshone-Paiute Tribes Vocational Rehabilitation Program

PO Box 219, Owyhee, NV 89832

Ph.: 775/757-2921

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AUTHORIZATION FOR RELEASE OF INFORMATION

For: _____
Name

Date of Birth

I hereby authorize the Shoshone-Paiute Tribes Vocational Rehabilitation to:

(Please check appropriate section)

Check Here		Initials
_____	Furnish	_____
_____	Receive	_____
_____	Furnish/Receive	_____

Share information pertinent to my disability: _____

Name of Person/Agency _____

Address _____

Phone Numbers _____

I understand that the information is essential to the continuity of my care and will be kept confidential and used for professional purposes only. Further, I understand I may revoke this authorization at any time in writing. This release of information does not have an automatic expiration date. You make accept a photocopy with the same authority of the original.

From Date: _____ To Date: _____

Signature: _____