DISCLOSURE OF INFORMATION AUTHORIZATION–VOC REHAB VETERAN

JOB SERVICE NORTH DAKOTA
WORKFORCE PROGRAMS
SFN 61028 (R. 8-19)

Provide information as it existed when the service was provided.

Participant Name (Last Name)	(First Name)	(Middle Initial)	
*Social Security Number		Date of Birth	
Street Address/PO Box	City	State	ZIP Code

AUTHORIZATION TO RELEASE INFORMATION

I, the participant, authorize:

ATTN: Marlene Seaworth, VRC
Vocational Rehabilitation & Employment
Bismarck CBOC VA Clinic
2700 State St Ste F
Bismarck ND 58503

to release information to:

State WOTC Coordinator
Job Service North Dakota
PO Box 5507
Bismarck ND 58506-5507

Is the participant currently receiving services under an individualized plan for employment (IPE) with veteran status? ☐ Yes ☐ No

If "no" indicate one of the following:
1) Date the IPE was completed (closed)

2) Participant never received IPE services ☐

Vocational Rehabilitation Services Staff Member Signature	Date

This information is being requested to establish eligibility for the vocational rehabilitation target group as part of the Work Opportunity Tax Credit (WOTC) program.

NOTE: **Please mail completed form to the State WOTC Coordinator, Job Service North Dakota**

PARTICIPANT AUTHORIZATION

This authorization is voluntary and remains in effect for one year from the participant or parent or guardian's date as listed below. If no date is indicated, it will remain in effect for one year from the date stamp of receipt by either JSND or VRS. If it is revoked by written notice to either agency, the effective date of revocation is the date of receipt by either agency. Any information disclosed either prior to or up until the date of receipt (by either agency) of the written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed to in writing, information may be disclosed under this authorization in any form or medium, including oral, written, or electronic transmission.

Participant Signature	Date
Parent or Guardian Signature ***(required if participant is under age 18, participant signature not required)***	Date
Witness Signature	Date

NOTE: **Please mail completed form to Vocational Rehabilitation Services**

Notice: Except for information subject to 42 CFR Part 2, information disclosed to another entity may potentially be re-disclosed, in which case it may not be protected by state or federal law.

*In compliance with the Privacy Act of 1974, a social security number is mandatory on this form pursuant to North Dakota Century Code 52-02-02. This number is used by Job Service North Dakota for identification, program eligibility purposes, and program performance accountability.

Confidentiality Notice: This facsimile, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, copy, use, disclosure, or distribution is prohibited. If you are not the intended recipient(s), please contact the sender by reply facsimile or phone and destroy all copies of the original message.

Job Service North Dakota is an equal opportunity employer/program provider.
Auxiliary aids and services are available upon request to individuals with disabilities.