**Authorization to Release Information**

**If you believe you may have a physical, visual, auditory, mental health, developmental, orthopedic or neurological condition that may qualify you for one of our employment programs, we would ask you to voluntarily complete this form, along with the Documentation of Disability Form, and return it with your employment application.**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_ Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Applicant Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_**

I agree that coordinating my rehabilitative and vocational services at Minnesota Diversified Industries (MDI) is important to my overall rehabilitation. I also understand that providing this information to MDI is voluntary. In order to facilitate this, I give permission to release the following information:

Please check one or more of the following that applies:

\_\_\_\_\_Medical Reports (any evaluations) \_\_\_\_\_Psychological Reports \_\_\_\_\_Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize this Information to be released to Minnesota Diversified Industries from:

*\_\_\_\_\_*Physician \_\_\_\_\_Psychologist/Psychiatrist

\_\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name and address of the provider identified above that is authorized to release information:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

By signing this form, I give MDI my permission to obtain / release the requested information for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (length of time, not to exceed 1 year) from the date of my signature. The consent starts on the date I sign this form. It lasts for the time period that I give my permission to use the information. I can stop this consent before then. If I want to stop my consent, I will tell MDI in writing. If I do that, my consent stops on the day that MDI gets my written notice. I understand that MDI cannot be held liable for any material released by this authorization. My signature on this form amounts to a waiver of any claim I might assert against MDI due to any good faith release of this information. I understand that MDI may be required to release certain employment information as part of legal processes. (e.g., subpoenaed information, audits by governmental agencies) and will provide this information if required to do so.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Signature Date