The State Education Department
Office of Adult Career and Continuing Education Services **ACCES-VR**
Elmira District Office
609 East Church Street
Elmira, NY 14901
(607)734-5294 or (800)888-5020

Transition Referral Transmittal Form for In-School Youth

STUDENT DEMOGRAPHIC INFORMATION: **Date: ______________________**

Student Name: Mr. Ms.____

DOB: ______________________________Social Security Number: _______________________________

Student Address: ____
Street City/State Zip Code

Parent/Legal Guardian Name/Address: #1 ____

Parent/Legal Guardian Name/Address: #2 ____

Home Phone #: (____) ______________________Other Phone Number: ____________________________

Grade Most Recently Completed: _________________ Expected Year of Graduation: __________________

STUDENT DIAGNOSTIC INFO:
Referral must include copies of:
Current IEP and psychological report (including subtest scores and observations) _____
or
Current 504 Plan and supporting documents _____
or
Current Physician Report with diagnosis _____

AND Signed release of Information ____

CSE Classification, 504 or Medical Diagnosis: ____

Special Accommodations for Initial Interview: ____

REFERRAL SOURCE INFORMATION:

Name of Person Making Referral: _________________________________Title __________________

School or Agency Referring: _________________________________ Phone Number: ____________________
Email Address: __________________

District BEDS CODE: __ __ __ __ __ __ __ __ _0_0_0_0_

School District Student Resides In: ____

Name of School Contact to help arrange interview: ____

Location of Student during school days: Mornings _____________________ until _____________________

Afternoons ____________________ until ____________________

STUDENT PARTICIPATION:
I wish to apply for vocational rehabilitation services

____________________________________ ____
Student Signature Parent/Guardian Signature (If under 18 years old)

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR)

Authorization to Release / Obtain Information

(Please read instructions on page two before completing this form.) **VR-22 (08/11)**

CONSUMER NAME	**CONSUMER ID NUMBER**

CONSUMER ADDRESS **[include street (apartment number or building, if applicable), city, state, zip]**

The Office of Adult Career and Continuing Education Services (ACCES-VR) has my permission to release or obtain information indicated in item #1 below. This information may include reports about my physical or mental condition, school records, facts necessary to determine my financial need, or other information that ACCES-VR needs to determine my eligibility and to provide vocational rehabilitation services. I understand that this information will be treated as confidential and privileged and will only be used for the purpose of obtaining services offered through ACCES-VR.

I can change my mind about this release, by telling ACCES-VR in writing that I do not want any further information to be given out. I understand that information disclosed according to this consent may be subject to re-disclosure and will no longer be subject to the HIPPA privacy requirements. This will not affect actions already taken with my permission.

My permission to release or obtain information expires on date ___________ or no later than one year from the date of signature, whichever is sooner.

1. What information is to be released or obtained? (Be specific.)

IEP, School Psychological, Medical or Psychiatric Records, and other Academic Records

Verbal and Written Communication between School and ACCES-VR

2. Who is releasing this information? (Insert the full name of this person or organization.)
(Insert School District Name) →

3. Who is receiving this information? (Insert complete information about this person.)

Name: Elmira Acces-VR Office
Title: ACCES-VR Staff
Address: 609 East Church Street, Elmira, NY 14901

4. Why is this information needed? For Eligibility Determination and Vocational Planning

I have read all of the information on this form. I understand and agree to what it says.

Consumer or Parent/Guardian Signature: ______________________________ Date: _________

This release meets all requirements of Title 45 section 164.508 of the Code of Federal Regulations, which implements HIPPA; Title 34 Part 99 of the Code of Federal Regulations, which implements the Family Education Rights and Privacy Act; and Title 42 Part 2 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse records. Form VR-540, Prohibition on Redisclosure of Information Concerning Individuals with a Disability of Alcoholism or Substance Abuse, must be attached to this form when necessary.

The State Education Department does not discriminate on the basis of age, color, religion, creed, disability, marital status, veteran status, national origin, race, gender, genetic predisposition or carrier status, or sexual orientation in its educational programs, services and activities. Inquiries concerning this policy of nondiscrimination should be directed to the Department's Office for Diversity, Ethics and Access, Room 530, Education Building, Albany, NY 12234

Authorization to Release / Obtain Information

Instructions

This Authorization to Release /Obtain Information form is to be used when information is to be released by or is to be requested by ACCES-VR. All such information will be treated as confidential and privileged and used only for the purposes of ACCES-VR services. Information ACCES-VR may have in the records, but obtained via a release from another provider, may be restricted from further dissemination.

If at any time the consumer wishes to terminate this release, he/she may do so by writing to ACCES-VR. Withdrawal of permission to release/obtain confidential information will not retroactively cover any information that has already been released or obtained.

You must:

- be as specific and precise as possible;
- not leave any questions unanswered;
- include a specific date on which the permission will end;
- include names of persons and titles or organization name receiving or sending information; and
- mark the VR-22 as void If the consumer rescinds his/her permission in writing to release/obtain further information.

Box #1: State the exact information that will be released/obtained (e.g., Medical Evaluation by Dr. Diaz dated 1/16/94; Educational Summary dated 10/5/95 from John Jay High School).

Box #2: State the name and title (if known) of the person releasing the information (e.g., Ms. Jean Jones, Vocational Rehabilitation Counselor; Dr. Browne, School Psychologist).

Box #3: Complete the name, title, and address of the person receiving the information. If an ACCES-VR counselor is sending the same document to several sources (e.g., a general medical report to a medical specialist and to an intake worker at a facility), multiple names, addresses, and titles can be filled in this box. It is not sufficient to indicate the report will be sent to a facility or program. **A specific individual must be indicated**, so that individual becomes responsible for the confidential information.

Box #4: Provide a brief summary that indicates why the information is needed.

The consumer or parent/guardian must sign and date the form at the bottom. This date sets the timeframe for which information may be exchanged under this release form. If a different expiration date is to be established this must be indicated on the form.