

Chautauqua WORKS

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

The purpose of the Authorization Form is to enable agencies identified as members of the *chautauqua WORKS* Consortium to better serve you and/or your child(ren) through coordinated service planning and delivery. Representatives of these agencies may share information in order to arrange for appropriate and prompt delivery of services as planned.

Is there any Agency that you do not want us to share your information with?
Yes ____ No ____

If Yes, please list the name(s) of the agency/agencies below:

The information that will be shared among participating *chautauqua WORKS* consortium will make it possible to coordinate the services you and/or your child(ren) receive. Check below the information you want to be shared.

- | | |
|--|---|
| <input type="checkbox"/> Customer Information | <input type="checkbox"/> Education/Training/Skills Background |
| <input type="checkbox"/> Employment Background and Information | <input type="checkbox"/> Support Service Information |
| <input type="checkbox"/> Eligibility | <input type="checkbox"/> Educational./Vocational Assessment Information |
| <input type="checkbox"/> Previous Workforce Prep. Services | <input type="checkbox"/> Unemployment Insurance |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

I understand and have had explained to me that this release authorizes an exchange of information between Service Agency members in order to provide me and/or my child(ren) with the most complete and thorough services available. It does not allow the release of HIV-related information, drug and alcohol records, or mental health reports. It does not authorize release to any other person or agency except those agencies which are partnership members' of *chautauqua WORKS*. Unless revoked in writing, this release and exchange shall remain in force for a period of 12 months from the date of authorization. My signature below indicates that I have been informed of and understand the eligibility information provided within this form and certify that it is true and correct and subject to verification. I understand I will have to provide specific documentation as requested by my workforce development specialist to be eligible for any financial assistance and if I do not comply I shall be personally liable for all costs incurred. I understand that falsification is grounds for termination and may result in action to recover any monies paid to me while participating in the program.

Signature of Participant

Signature of Parent/Guardian
(When Required)

Date

Date

Print Name

Print Name

Eligibility Interviewer/Specialist

Registration Date

Acknowledgement of Receipt of Notice of Rights

I have read this form and understand that I have a right to file a grievance or a discrimination complaint if I feel that my rights were violated by Chautauqua Works or in connection with a WIA Title I financially assisted program or activity.

I acknowledge receipt of the formal Grievance/Complaint/Reasonable Accommodations policies in addition to this Notice of Rights.

Signature: _____

Date: _____