

# Joint Educational Services in Special Education

P. O. Box 418  
Plymouth, IN 46563  
574-936-2627

## VOCATIONAL REHABILITATION RELEASE OF INFORMATION FORM

(Permission to disclose personally identifiable information and permission to invite Transition Service Agency Representative)

Student Name: \_\_\_\_\_

Student Address: \_\_\_\_\_

\_\_\_\_\_  
City, State, Zip Code

Student Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Disability: \_\_\_\_\_

County of Residence: \_\_\_\_\_ School: \_\_\_\_\_

Anticipated Date of Graduation: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

I hereby give permission to disclose personally identifiable information from my child's educational record to Vocational Rehabilitation. I also give permission for the Vocational Rehabilitation Counselor to be invited to the Annual Case Conference during my child's Junior and Senior year of high school.

I reserve the right to revoke this consent at any time. I understand that I can revoke this consent by notifying School Administration. If not revoked, this consent will expire one year from signature date.

\_\_\_\_\_  
Date: \_\_\_\_\_

Parent Signature (or Student if 18 years or older)