Iowa Workforce Development

WAIVER AND AUTHORIZATION

Iowa Workforce Development and/or
Iowa Vocational Rehabilitation Services, a division of Iowa Workforce Development, is hereby authorized to provide records listed below to:

Name: _____

Address: _____

If I am a claimant of Iowa Workforce Development, I allow the release of any personal and/or business information concerning unemployment insurance claims, accounts, or any other pertinent information regarding my interactions, past or present, with Iowa Workforce Development.

If I am a client of Iowa Vocational Rehabilitation Services, I allow the release of any of my client records, including medical, hospital, psychiatric, psychological, educational transcripts, etc., subject to eCFR34; CFR361.38

Dated this _____day of _____,_____

_____
Signature

_____ _____
Full Name of Claimant, Client **or** Employer | Full Social Security Number **or** EIN Number

_____ _____
Claimant's or Client's Date of Birth | Telephone Number

IVRS Clients – Please initial next to each category if you give permission to share the listed protected records

____**Substance abuse**

____**Mental health**

____**HIV-related information**

Question	**Answer**
Current Employer Name	
Last Date Worked	
Amount of Last Benefit Payment	
Number of Dependents	
Start Date with Last Employer	