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**Pre-Employment Transition Services Permission**

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| FIRST NAME | LAST NAME | | MIDDLE NAME |
| SOCIAL SECURITY NUMBER | DATE OF BIRTH | GENDER | RACE/ETHNICITY |
| ADDRESS | | | PHONE NUMBER (Include area code) |
| EMAIL ADDRESS | | | ALTERNATE CONTACT INFORAMTION |
| **I hereby authorize the student listed above to participate in Pre-Employment Transition Services. I authorize the Local Education Agency to release Disability Certification information to the Department of Human Services, Vocational Rehabilitation Program (VR). I understand that this information will be treated in a confidential manner by VR and is not protected under the Health Insurance Portability and Accountability Act (HIPAA).**  **Participation in Pre-Employment Transition Services does not qualify this individual for Vocational Rehabilitation services.** | | | |
| Parent □ /Guardian □ /Adult Student □  Signature: Date: | | | Printed Name: |
| County | | School | |