**Attachment A:**

**Workforce Innovation and Opportunity Act**

**Interagency Release of Information Form**

**Participant Name:** Participant Name

**Participant Address:** Participant Address

I authorize only the Workforce Innovation and Opportunity Act (WIOA) partner agencies listed below to obtain, or release written documentation, and/or discuss any employment related information indicated below with each other to assist me in my employment and training efforts.

My permission to discuss information is only valid until **Enter End Date** and cannot extend beyond one year from the date I sign this form, whichever is sooner.

I can change my mind about this release, by telling the initiating agency identified below, in writing, that I do not want any further information to be given out or discussed.

Information to beobtained, released, and/or discussed by an agency must be for its program purposes, associated with a referral, and only to the extent the other agency demonstrates that the information requested is necessary for its program. No medical and/or disability information is to be provided under this release. I give my permission for the checked items listed below to be shared:

[ ]  My contact information.

[ ]  My work history/experience.

[ ]  My education/skills/abilities.

[ ]  My career/skill assessment results.

[ ]  My income level/benefit eligibility.

[ ]  My eligibility/enrollment and/or attendance in workforce system programs.

[ ]  The accommodations I need to access training or services or to find,

 obtain, or retain employment.

**WIOA agencies releasing/receiving/discussing this information:**

**Initiating Agency Name:** Initiating agency name

**Agency Address:** Initiating agency address

**Telephone:** Initiating agency phone **Email:** Initiating agency email

**Agency Name:** Second agency name

**Agency Address:** Second agency address

**Telephone:** Second agency phone number **Email:** Second agency email

**Agency Name:** Third agency name

**Agency Address:** Third agency address

**Telephone:** Third agency phone number **Email:** Third agency email

**Agency Name:**Fourth agency name

**Agency Address:** Fourth agency address

**Telephone:** Fourth agency phone number **Email:** Fourth agency email

**Agency Name:** Fifth agency name

**Agency Address:** Fifth agency address

**Telephone:** Fifth agency phone number **Email:** Fifth agency email

**I have read, understand and agree to all the information in this document.**

Participant or Authorized

Representative/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**WIOA Agencies**: The information being disclosed to you may be from records protected by state or federal confidentiality rules which prohibit you from making any further disclosure of this information unless said further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise legally permitted. It is understood and accepted that this Release Form is not sufficient to, and is not intended to allow for, providing informed consent for the release of confidential Unemployment Insurance (UI) data pursuant to New York State Labor Law §537(1)(d); medical information pursuant to the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); education information pursuant to the Family Educational Rights and Privacy Act (FERPA) (34 Code of Federal Regulations (CFR) Part 99);Mental Health Information (New York State Mental Hygiene Law Sections 19.17, 23.05 and 33.13; Alcohol/Drug Treatment (Public Health Services Act ) (42 CFR Part 2); or HIV related Information (New York State Public Health Law Article 27- F)