# Individual Career Advancement Network

## General Authorization to Release Information

**** may be signed with physical, electronic or telephonic (with documentation) signature ****

Participant name_____ Last 4 digits of SSN _____

Head of household name_____ Last 4 digits of SSN _____

Phone/email contact information _____

Name of legal representative (if applicable) _____

The Individual Career Advancement Network (ICAN) hosts a multidisciplinary team that provides training, education, and support services for people who are overcoming obstacles to employment. The team is made up of professionals who provide services to assist the participant to improve his or her earning capacity.

**I, or my legal representative, give permission for the ICAN team members and the following community providers:**

**ICAN Team Members:**

Economic Services Division
Vocational Rehabilitation – Employee Assistance Program
Vermont Department of Labor
VABIR
Vocational Rehabilitation

**Additional ICAN Team Members (Check all that apply):**

☐ Working Fields
☐ Community Kitchen Academy – Vermont Foodbank, Capstone Community Action, Feeding Chittenden (CVOEO)

**Community Providers (Check all that apply):**

☐ Housing Assistance Provider:
☐ Probation and Parole Officer:
☐ Restorative Justice:
☐ Adult Basic Education:
☐ Employer:
☐ Agency of Human Services Field Director:
☐ Transportation Provider:
☐ Community Action (please identify program):
☐ Other:

**3SquaresVT Outreach Partners**

☐ Vermont Foodbank
☐ Other _____

*Outreach partners can provide support to you and your ICAN provider regarding 3SquaresVT enrollment and eligibility.*

# Individual Career Advancement Network

## General Authorization to Release Information

**** may be signed with physical, electronic or telephonic (with documentation) signature ****

**To communicate with and disclose to one another the following information (check all that apply):**

☐ Information pertaining to your participation in ICAN including employment plan

☐ Information pertaining to support services

☐ Relevant information shared by me with anyone other than a health care provider concerning my physical or mental health

**The purpose(s) of the disclosures authorized is (check all that apply):**

☐ To determine services necessary for me

☐ To coordinate services across all ICAN team members

☐ To consult with professionals associated with the ICAN team in my region when needed

☐ Other: _____

**By signing this form, I understand:**

- The reason(s) I am being asked to release information.
- I do not have to agree to the release of information. However, by not giving authorization, I may not be able to participate in the services available through ICAN.
- If I choose not to sign this form any Economic Services Division benefits for which I or my family are entitled will not be affected.
- If I do not revoke or update this authorization, it will be in effect as long as I am receiving ICAN services.
- I will be provided a copy of this form.
- All items on this form and my questions about this form have been answered.

Participant signature _____ Date _____

Legal representative signature (if applicable) _____ Date _____

Name of person explaining authorization process _____

Organization/position _____ Date _____

---

Complete the section below if the form was completed and signed telephonically.

_____ spoke with _____ on _____ and agreed to authorize the release of
Participant Name ICAN Staff Name Date

information indicated on the form above.