Georgia Vocational Rehabilitation Agency
Vocational Rehabilitation Program

Name of Client/Patient/Applicant

Date of Birth

Assignment of an Authorized Representative

I _____ hereby authorize:
Print Name

_____
(Name of Authorized Representative)

_____
(Address & Phone Number)

To serve as my authorized representative and in doing so I hereby release the Vocational Rehabilitation Program from all legal responsibility or liability that may arise from releasing information from my file to my representative.

_____ _____
(Signature of Client/applicant) (Date)

_____ _____
(Signature of Parent or Authorized Representative, if applicable) (Signature & relation of Witness) (Date)

FOR WITHDRAWL OF CONSENT

_____ _____
(Authorization is revoked) (Signature of client)