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)