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## Release of Information

I, \_\_\_\_\_ hereby authorize the Deaf Centers of Nevada (DCN) to transfer my current client file to the State of Nevada Aging and Disability Services Division (ADSD) for continued services.

If my current client file contains material obtained from other sources (including but not limited to, legal, health care, educational, employment, or financial services), I specifically authorize the release of a complete copy of such records to ADSD.

A photocopy or fax of this release shall be honored by DCN and ADSD as if it were the original.

I understand I may revoke my consent at any time. This consent is valid until \_\_\_\_\_ (date), unless sooner revoked.

I, \_\_\_\_\_ do not wish to continue services with the State of Nevada Aging and Disability Services Division (ADSD). As such, I understand my client file, including any confidential information, will not be transferred to ADSD. I understand I can contact ADSD if I should need services in the future.

### Client, Parent or Legal Representative:

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

Print Name: \_\_\_\_\_

### Appointed DCN Board Member:

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

Print Name: \_\_\_\_\_

**In completion of this form please mail or email the above signed document to [DCNboard@dcnv.org](mailto:DCNboard@dcnv.org) and/or PO Box 60823, Boulder City, NV 89006. Files will be released to the above stated party within 30 days of receipt of this form.**