

A	Student's Full Name: _____ Student's DOB: _____ <div style="text-align: center; margin-top: 5px;">(Please Print)</div>
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B	<p>I hereby authorize the release of records:</p> <p>From: _____ To: Virginia Project for Children and Young Adults with Deaf-Blindness (Name of agency/person)</p> <p>_____ (Street address)</p> <p>_____ (City, State, Zip)</p> <p>() _____ (Phone)</p> <p>() _____ (Fax)</p> <p>Mark the records to be disclosed:</p> <p> <input type="checkbox"/> Vision <input type="checkbox"/> Educational including IEP and Assessment Summaries <input type="checkbox"/> Hearing <input type="checkbox"/> Medical <input type="checkbox"/> Other (specify): </p>
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PO BOX 843020
Richmond, VA 23284-3020
Phone: (804) 828-8252
or (877) 795-7799
Fax: (804) 828-0042

C	<p>The reason for the disclosing the record(s) is: To determine eligibility for services as a child/youth with dual sensory impairment/deaf-blindness based on <u>combined</u> hearing and vision impairments and to inform potential technical assistance requests. I understand that this information obtained will be treated in a confidential manner by the Project under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that of the request is for health or medical information, the medical information received by the Project is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).</p> <p>This authorization is valid from _____/_____/_____ to _____/_____/_____ (date of signature) (one year from date of signature)</p> <p><i>Note: For release of medical records, the authorization can be no longer than 90 days after authorization is signed.</i></p> <p>I understand that my consent for the release of records is voluntary and I can withdraw my consent at anytime in writing. Should I withdraw my consent, it does not apply to information that has already been provided under prior consent for release.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border-top: 1px solid black; padding-top: 5px;">Father's/ Guardian's Name (if appropriate)</td> <td style="width: 50%; border-top: 1px solid black; padding-top: 5px;">Mother's/ Guardian's Name (if appropriate)</td> </tr> <tr> <td style="border-top: 1px solid black; padding-top: 5px;">Parent/Guardian Address</td> <td style="border-top: 1px solid black; padding-top: 5px;">Child's Address (if different)</td> </tr> <tr> <td style="border-top: 1px solid black; padding-top: 5px;">City, State, Zip</td> <td style="border-top: 1px solid black; padding-top: 5px;">City, State, Zip</td> </tr> <tr> <td style="border-top: 1px solid black; padding-top: 5px;">Phone</td> <td style="border-top: 1px solid black; padding-top: 5px;">E-mail</td> </tr> <tr> <td style="border-top: 1px solid black; padding-top: 5px;">Signature of Parent/Legal Guardian/</td> <td style="border-top: 1px solid black; padding-top: 5px;">Relationship to Child</td> </tr> <tr> <td style="border-top: 1px solid black; padding-top: 5px;">Date</td> <td></td> </tr> </table>	Father's/ Guardian's Name (if appropriate)	Mother's/ Guardian's Name (if appropriate)	Parent/Guardian Address	Child's Address (if different)	City, State, Zip	City, State, Zip	Phone	E-mail	Signature of Parent/Legal Guardian/	Relationship to Child	Date	
Father's/ Guardian's Name (if appropriate)	Mother's/ Guardian's Name (if appropriate)												
Parent/Guardian Address	Child's Address (if different)												
City, State, Zip	City, State, Zip												
Phone	E-mail												
Signature of Parent/Legal Guardian/	Relationship to Child												
Date													