A Shared Vision
Partners in Pediatric Blindness and Visual Impairment

Authorization for Mutual Exchange of Information

As the parent or legal guardian of _____ (child's name), who's date of birth is _____, **I authorize A Shared Vision to exchange educational and developmental information pertaining to this child, including but not limited to:**

- ☐ Referral Information
- ☐ Developmental Screening Results
- ☐ Health Records
- ☐ Eye Exam Results
- ☐ Functional Vision Assessment
- ☐ IFSP
- ☐ Other: _____

with the following agencies, physicians or programs (use the back of this page if more than three to be listed):

Name: _____

Address: _____

Name: _____

Address: _____

Name: _____

Address: _____

for the purpose of:

- ☐ Determination of Eligibility for Early Intervention Services
- ☐ Developmental and Educational Planning
- ☐ Transition Planning
- ☐ Other: _____

I understand that this authorization will be valid for one year after A Shared Vision's last active contact with my family and may be revoked at any time with a written request to A Shared Vision. I understand that signing this authorization is not a condition of receiving future medical or early intervention services. There is the potential for redisclosure of this information to others, in which case it may no longer be protected under the HIPAA Privacy Rule. It is A Shared Vision's policy to not disclose a child's information without consent of the parent / legal guardian. For more information, see 45 CFR (Code of Federal Regulations) 164.508 for HIPAA and 34 CFR Part 99 for FERPA.

_____ Print Full Name

_____ Relationship to Child

_____ Signature of Parent/Legal Guardian

_____ Date