COLORADO SERVICES FOR CHILDREN AND YOUTH WITH COMBINED VISION AND HEARING LOSS

(Dual Sensory Impairment, Deafblind, Dual Sensory Loss)

Authorization for Mutual Exchange of Information

Child's Name: _____

Address: _____ City, State, Zip: _____

Date of Birth: _____

I, the parent or guardian, do hereby authorize the mutual exchange of vision, medical, psychological, speech, audiology, occupational therapy, physical therapy and education information regarding the above child, between:

Colorado Services for Children and Youth with Combined Vision and Hearing Loss
Colorado Department of Education
1560 Broadway, Suite 1100
Denver, CO 80202

And/or

Agency / Agencies:

1. _____
_____
_____

2. _____
_____
_____

3. _____
_____
_____

4. _____
_____
_____

5. _____
_____
_____

6. _____
_____
_____

I understand that all practices of confidentiality will be followed in use of information gathered. This release is valid for five years from the date when it is signed.

_____ _____ _____

Signature of Person Giving Consent | Relationship | Date Signed

A copy of this form may be sent to each agency/person listed. If you do NOT wish all agencies listed to receive this, please advise on the back of this form.

Gina Herrera
Colorado Department of Education
1560 Broadway Avenue, Suite 1100
Denver, CO 80202
303-866-6605