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

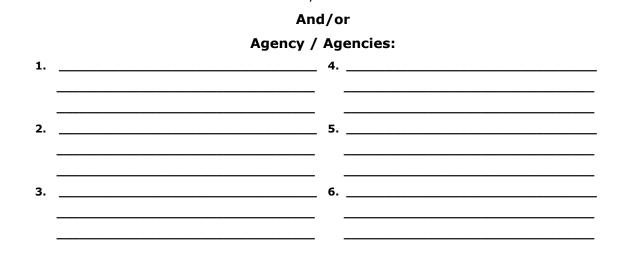
(Dual Sensory Impairment, Deafblind, Dual Sensory Loss)

## Authorization for Mutual Exchange of Information

Child's Name:		
Address:	City, State, Zip:	
Date of Birth:		

I, the parent or quardian, 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



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