HEAR TO LEARN, LLC

AUTHORIZATION TO RELEASE AND CONSENT TO EXCHANGE INFORMATION

Student Name:_____ D.O.B. _____

Address: _____ Phone: _____

Parent/Guardian: _____ Parent/Guardian Email: _____

I authorize my child's educational team and (school name) _____ to request and/or exchange confidential information with HEAR TO LEARN pertaining to above named child for the purpose of Service Coordination, Treatment/educational planning, Eligibility Determination, and any additional services agreed upon by the team to support the planning and implementation of my child's school programming.

My consent to the exchange of information applies to the following sources of information (check all that apply):

☐ Assessment Information ☐ Psychiatric Records

☐ Audiology Records ☐ Medical Diagnosis/Medical Records

☐ Educational Records

I authorize the mutual exchange of information between HEAR TO LEARN and the following AUDIOLOGIST/PHYSICIAN/OTHER PROVIDER(S):

Provider Type	Name	Phone	Email/Fax

I authorize HEAR TO LEARN personnel to exchange information pertinent to my child's education as needed with the following additional persons(s), agencies, or other third parties: (examples include SERESC, Strafford Learning Center, Northeast Deaf and Hard of Hearing Services)

Name	Address	Phone	Email

I have read and understand this authorization and consent will remain effective until I revoke it by notifying the agencies or individuals orally or in writing. This will stop the exchange of information authorized by this document. Information exchanged will only be used/disclosed by Hear to Learn as needed to serve the legitimate educational needs of my child. Some confidential correspondence related to my child may take place over email, and I consent to Hear to Learn corresponding over email concerning my child as needed.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____