School for the Deaf and the Blind
embracing the possibilities

Authorization for Release of Information

Student's Name: _____ Date of Birth: _____

Address: _____

I hereby authorize the South Carolina School for the Deaf and the Blind to exchange pertinent information to/from the following entities for the purposes of educational planning and/or provision of services (list agency/organization and phone number):

_____

_____

_____

_____

_____

_____

Requested Information:

☐ Special Education Records

☐ General Education Records

☐ Medical Records (Select all that apply)

☐ Health ☐ Hearing ☐ Motor ☐ Speech ☐ Vision

☐ Other: _____

I understand this information will be used to assist in educational planning and/or in the provision of services, including health care, for my child. I understand that this authorization is valid for one calendar year from the signature date. I understand that at any time I may revoke this authorization, except to the extent that SCSDB has already taken action based upon released information. I also understand that in order to terminate this authorization I must submit a statement in writing to SCSDB and/or any office/agency covered under the release.

Signature _____ Date _____

I am the ☐ Parent ☐ Guardian ☐ Adult Student