New Jersey Center on Deaf-Blindness
(NJCDB)

CONSENT TO RELEASE FORM

NJCDB is responsible for maintaining a registry of students with deaf-blindness as required by the US Office of Special Education and Rehabilitation Services (OSERS). As the agency with the assigned responsibility, NJCDB will securely maintain the confidentiality of all information collected. *Please note that the term "students with deaf-blindness" refers to children and youth (birth to 21 years) with varying degrees of vision and hearing loss.*

To Whom It May Concern:

I authorize the release of any **medical, educational, and/or other information** concerning my child, ________________________________ ,to NJCDB with the understanding that these confidential records will be treated as privileged information, and the information being requested is necessary for purposes directly related to technical assistance provided by NJCDB on behalf of my child. I hereby give permission to the New Jersey Consortium on Deaf-blindness (NJCDB) to determine eligibility for services for my child. I further understand if my child is found eligible for services, that he/she will be placed on the NJCDB-NCDB child count.

If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing by sending a letter signed and dated to any NJCDB staff and such rescission will take effect upon receipt by NJCDB staff and your child will be removed from the census and services will be terminated.

______________________________	______________________________
Print or Type Full Name	**Relationship to child/youth**
______________________________	______________________________
Signature	**Date**
______________________________	______________________________
Phone	**Email**

For the purpose(s) of sharing (check only those that apply):

☐	School Reports (IEP, MET)	☐	Orientation & Mobility Reports/Summaries
☐	Speech & Language Evaluation/Information	☐	Audiological/Hearing Evaluation(s) and Info.
☐	Occupational/Physical Therapy Eval/Info	☐	Vision Records
☐	Family, Birth & Developmental History	☐	Psychological Reports/Info.
☐	Medical Information	☐	Other (Please Note Below): ____________

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- Would you allow us to talk to your child's teacher, paraprofessional, or other staff members about specific issues related to your child and the review your child's educational and medical records?

  Yes_____ No____

- Would you allow us to release contact information to parent advisors in order to contact you about upcoming events?

  Yes_____ No____

- Would you like to be included on NJCDB's mailing/call list to receive notices of workshops, services, or be contacted by a representative to learn about our services?

  Yes_____ No____

- Would you allow us to release parent contact information to disability specific organizations?

  Yes_____ No____

- Would you like more information about our state Parent Training Information Training Center (PTI)?

  Yes_____ No____

- Transition-aged Youth (13-21): Would you allow us to share your contact information (only) with the Helen Keller National Center regional representative?

  Yes_____ No____

Child's Name (First & Last) ____

Date of Birth ____________

Address ____

City____________________________**State** _______ **Zip** __________________

New Jersey Center on Deaf-Blindness
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