New Jersey Center on Deafblindness
(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 Center 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.

Child's Name (first and last): ____

Child's Date of Birth: _________________

Address: ____

City: ___________________ State: NJ Zip Code: ________________

Parent/Guardian Full Name: ____

Relationship to child/youth: ____

Phone: ____

Email: ____

Signature: ____ Date: ___________

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____

New Jersey Center on Deaf-Blindness
The College of New Jersey
P.O. Box 7718 Ewing, NJ
(609) 771-2744
http://njcscd.tcnj.edu

IDEAs that Work
Office of Special Education Programs
U.S. Department of Education
H326T180008

(optional)

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

_____ School Reports (IFSP, IEP, MET)
_____ Speech & Language Evaluation/Information
_____ Occupational/Physical Therapy Evaluation/Information
_____ Family, Birth & Developmental History
_____ Medical Information
_____ Orientation & Mobility Reports/Summaries
_____ Audiological/Hearing Evaluation(s) and Information
_____ Vision Records
_____ Psychological Reports/Information
_____ Other (please describe): ____________________________________

Additional Consent:

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 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____

Initial here: __________________ Date: ___________________

Child Name: ____