COLORADO DEPARTMENT OF EDUCATION

COLORADO SCHOOL FOR THE DEAF AND THE BLIND
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William J. Moloney
Commissioner of Education

Dorothy Gotlieb
Deputy Commissioner

Shared Release of Confidential Information

Child's Name________________________ Date of Birth_______________

Parent/Guardian ______________________

I hereby authorize the agencies initialed below to share pertinent information concerning my child or family. This information may include my child's health records and school records (IEP/IFSP). I understand that this information can be shared by verbal communication or written exchange of information, and will only be shared with the listed agencies in order to better coordinate services for my child and family.

(Initial all agencies that may share information)

_____Health Care Program for Children with Special Needs (HCP)

_____School District/Child Find____

____ Community Centered Board (CCB)_____________________________________

____ Physician (PCP)____

____ Physician (ENT)____

____ Audiologist____

_____Colorado Hearing Resource (CO-Hear) Coordinator

_____Colorado School for the Deaf and Blind (CSDB)

____Hands and Voices

____ Other____

Date ______________ Signature of Parent/Guardian____________________

Date ______________ Signature of Witness___________________________

Authorization valid until revoked in writing by parent/guardian or until child is no longer served by CHIP.

cde *Improving Academic Achievement*

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