

**Outreach Services
Missouri School for the Blind
Release of Information**

I understand that many agencies provide a variety of services and benefits. Each agency must have specific information in order to provide these services and benefits. By signing this form, I am allowing the named agencies to exchange specific information to effectively provide or coordinate services and benefits.

A. I, _____ give my informed consent for
(Parent/Legal Guardian Name)

information regarding _____ / _____ to be
(Child's Legal Name) (DOB)

mutually exchanged/shared between the providers below:

_____	AND	<u>Outreach Services</u>
Ophthalmologist/Eye Doctor Name		Missouri School for the Blind
_____		3815 Magnolia Avenue
Provider Address		St. Louis, MO 63110
_____		FAX: 314-776-1875
_____		For questions, call: 314-633-1582
Email/Phone/FAX		

B. The purpose of the exchanged/shared information is to:
Assist in determining eligibility
Plan and provide service; specify service: Assessment and technical assistance
Other: Conduct Functional Vision and Learning Media Assessment (FVLMA)
Other: Conduct Orientation and Mobility

C. This consent includes the following types of information: (as checked)
Eye report/ophthalmological; specify dates of service:
Hearing and audiological care; specify dates of service: _____
Other health and medical records; specify type and date of service: _____
IFSP/IEP/ 504 Plan
Current educational evaluation
Other; specify:

D. I understand:

- I have the right to inspect and receive a copy of the information to be shared.
- I am providing my consent voluntarily and I understand the information on this form.
- I have a right to revoke this release at any time. I understand that if I revoke this release, I must do so **in writing** and present my written revocation to Outreach Services, Missouri School for the Blind, 3815 Magnolia Avenue, St. Louis, MO 63110. I understand further that actions already taken based on this release, prior to revocation, will **not** be affected.
- This release of information will remain in effect for one year unless I specify an expiration date. Indicate specified expiration date here: _____

F.

Signature (Parent/Legal Guardian)	Date

Address	

Phone Number	

Email	

If release is signed by a personal representative of the individual, please include a description of authority on the child’s behalf and attach a copy of the document granting authority.

The Department of Elementary and Secondary Education does not discriminate on the basis of race, color, religion, gender, national origin, age, or disability in its programs and activities. Inquiries related to Department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Office of the General Counsel, Coordinator – Civil Rights Compliance (Title VI/Title IX/504/ADA/Age Act), 6th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number 573-526-4757 or TTY 800-735-2966; fax number 573-522-4883; email civilrights@dese.mo.gov.