

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, request that _____
(e.g. - Children's Hospital, Sunny Hill Health Centre for Children, Queen Alexandra Centre for Children's Health, Shriners Hospital, etc.) release the reports indicated below to the Provincial Outreach Program for Students with Deafblindness for their screening meeting. Please mail the reports directly to them at: 10300 Seacote Road, Richmond, BC V7A 4B2

Name of Student _____ Birthdate: _____

Parent/Guardian (please print): _____ Signature: _____

Witness (please print): _____ Signature: _____

Signed at (location): _____

This _____ day of _____ 20 _____

Please Indicate the Reports to be Released

Audiological

Ophthalmological

Medical

Technology Assessment

Other Provincial Resource Programs

Other

Other

Please send the reports to:

PROVINCIAL OUTREACH PROGRAM FOR STUDENTS WITH DEAFBLINDNESS
10300 Seacote Road, Richmond, BC V7A 4B2 Tel: (604)668-7810 Fax: (604)668-7812