



- Initial Contact
- 3-Yr Old Transition
- Primary Care Physician
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_

SC Site: \_\_\_\_\_

## RELEASE/REQUEST FOR INFORMATION

Authorization is given to DDI VANTAGE, to share with, furnish to and receive from,  
 Parent Infant Program (PIP), Utah School for the Deaf and Blind (USDB), Utah Department of Health,  
 Speech, Hearing and Vision Services; and Dual Sensory Impairment (DSI) SKLHL

Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Information necessary for determining eligibility and planning early intervention services for:

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 DOB \_\_\_\_\_

**I authorize the release and sharing of any or all of the following records/information with appropriate health care providers:**

	Initial Social/Health Summary		Social History
	Motor Evaluation or Summary		Medical Reports (including Occupational Therapy, Physical Therapy, Speech Therapy, and Audiological records) Specifically _____
	Communication Report or Summaries		Psychological Reports
	Developmental Profiles		Educational
	Two-way Communication		Other
	Child Health and Demographic Information		

My signature below indicates that my consent is given voluntarily and may be revoked at any time. It also indicates that I have been informed that all information will be kept confidential and used for professional purposes only.

\_\_\_\_\_  
 Parent or Legal Guardian \_\_\_\_\_  
 Date

- \* This release expires one year from the date of signature.
- \* This request is compliant with privacy protection required under FERPA.

