(DBS-017 Revised 10/09)

FLORIDA DEPARTMENT OF EDUCATION
DIVISION OF BLIND SERVICES

Authorization for Release of Information

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Phone Number: _____

☐ I authorize the Division of Blind Services to release information to:

_____
Name of Provider or Facility

Two-6 Resources, Inc.
_____
Address 1027 Sligh Boulevard
Orlando, FL 32806

_____
City, State, Zip Code

407-894-5051
_____
Phone #/Fax # (Include area code)
407-894-5490 Fax

AND/OR

☐ I authorize the Division of Blind Services to obtain information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (Include area code)

PURPOSE OF THIS REQUEST: This information will only be used for my plan of services. This information will not be released to anyone else without my written request.

TYPE OF RECORDS AUTHORIZED:

☐ Medical ☐ Psychological

☐ Eye Medical ☐ Other_____

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ Assessments ☐ Progress Notes ☐ Laboratory Test Results: _____

☐ Diagnostic Impression ☐ School Records ☐ Treatment Plans

☐ Treatment Summary

☐ Other: _____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**

☐ When the requested information has been sent/received.
☐ 90 days from this date. ☐ Other: _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.

My authorization will expire:

☐ When I am no longer receiving services from the Division of Blind Services.
☐ One year from this date. ☐ Other: _____

I understand that:.

- I may cancel this authorization at any time by submitting a *written* request to the Division, except where a disclosure has already been made in reliance on my prior authorization.
- This document may be produced in alternative formats such as Braille, large print and audiotape.

Signature of Client or Representative: _____ Date: _____

Relationship to Client *(if requester is not the student)*: ☐ Parent ☐ Legal Guardian ☐ Other: _____