(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:

D **I** authorize the Division of Blind Services to release information to:

AND/OR

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

Name of Provider or Facility:

Two 6 Resources

Address:

1027 Sligh Blvd

City, State, Zip Code:

Orlando, FL 32806

Phone #/Fax #

407-894-5051, 407.894.5490

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:

D Medical D Eye

Medical

D Psychological

□ Othe

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

□ Assessments D 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. D 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:_____

/ *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: