



THE UNIVERSITY OF GEORGIA

College of Education

Communication Sciences and Special Education
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GEORGIA
SENSORY
ASSISTANCE
PROJECT

GSAP is a federally funded project to assist families and schools work with children who have combined vision and hearing losses. Your child's school has invited GSAP to offer suggestions for teaching strategies. We welcome your participation in the process. Please let us know if you have any questions.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

To: _____ **Phone:** _____
Address: _____ **FAX:** _____
 _____ **email:** _____

I hereby authorize release of the information and confidential records for my child as indicated below **to/from** Georgia Sensory Assistance Project.

Child's Name: _____ **Date of Birth:** _____
Address: _____
 Street City State Zip

YES	NO	Please check YES or NO for each of the permissions below:
		1. Would you allow GSAP staff to talk with your child's teacher about specific issues related to your child and to review your child's education and medical records ?
		2. Would you allow us to share and exchange information about your child with other agencies that provide services for children with combined vision and hearing loss, including the National Center of Deaf-Blindness (NCDB), the Georgia Vocational Rehabilitation Agency (GVRA), and/or iCanConnect Georgia?
		3. Would you allow us to attend team meetings discussing your child, including IEP meetings?
		4. Would you like for one of our Family Support Coordinators to contact you? If yes, please circle your contact preferences: phone or email ? day or evening ?

I understand the release of this information is voluntary. I understand that I may revoke this authorization at any time by contacting GSAP.

Parent/Guardian Name Phone email

Parent/Guardian Signature Date

If you have questions, contact Christine Spratling csprat61@uga.edu (706) 346-0417
PLEASE RETURN THIS FORM to YOUR CHILD'S TEACHER/PROVIDER or GSAP (see above)