THE UNIVERSITY OF GEORGIA
College of Education
Communication Sciences and Special Education
570 Aderhold Hall, Athens, GA 30602-7152
http://gsap.coe.uga.edu ~ FAX (706) 542-5348

GSAP Georgia Sensory Assistance Project
Supporting Children and Youth with Combined Vision and Hearing Loss

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

To:	Georgia PINES	**Phone:**	(404) 298-4880
Address:	Georgia Department of Education	**FAX:**	(404) 298-3610
	890 North Indian Creek Dr.		
	Clarkston, GA 30021		

I hereby authorize release of the confidential records on my child that are checked below **to/from** Georgia Sensory Assistance Project.

Child's Name: _____ **Date of Birth:** _____

Address: _____

Street **City** **State** **Zip**

- √ Vision Report
- √ Audiological Report
- √ Otologic Exam Report
- √ Orientation & Mobility (O&M) Assessment
- √ Functional Vision Assessment (FVA)
- √ Early Intervention Records (IFSP, IPP, Assessments, Visit Notes)
- ____ IEP and Related Assessments
- ____ Other (specify) _____
- ____ Other (specify) _____

Reason for request:
- √ verify eligibility
- √ plan appropriate technical assistance and collaboration of services

I understand the release of this information is voluntary. I understand that I may revoke this authorization at any time. I understand that the party to whom this information is released will not release it to a third party without my written consent. I place no limitations on history or illness (including HIV and/or AIDS, genetic, drug dependency or psychiatric information) or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse or psychiatric disorders.

This authorization expires: _____

Signature **Date** **Printed Name** **Relationship**

PLEASE RETURN THIS FORM to GSAP