Clarke Schools
for Hearing and Speech

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New York, NY 10028-8004

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clarkeschools.org

CONSENT TO OBTAIN/RELEASE MEDICAL AND/OR EDUCATION INFORMATION

In order for Clarke to communicate, discuss, request or share private/confidential information with other individuals or providers, the parent/legal guardian must consent in writing and specify what information can be shared and with whom. Please fill in one form for each person or agency (for example, one form for the pediatrician and one form for the audiologist.)

Child's Name:	DOB:

I consent to the communication of medical or educational information about my child between Clarke School for the Deaf dba Clarke Schools for Hearing and Speech and the following individuals/organization:

Name:	
Address:	
Phone #	
Fax #	
Email Address:	
Please include any restrictions or limits to this release:	

Such information includes:

- ☐ Audiology Evaluations and Reports
- ☐ Health/Physical Forms
- ☐ MAPping/CI Program reports
- ☐ Prescriptions for service
- ☐ IFSP/IEP
- ☐ Prescription for OT, PT, Speech
- ☐ Psychological Evaluations or Reports
- ☐ Psychiatric Report
- ☐ Progress Reports
- ☐ Speech/Language Evaluation Reports
- ☐ Other _____
- ☐ Other_____

☐ In addition, I give Clarke consent to release the above checked information to the same individual(s) listed above with the exception of: _____

_____

Parent Signature Date

This release will expire at the end of 1 year unless consent is revoked, in writing, before that time.