AUTHORIZATION FOR RELEASE OF INFORMATION

NORTH DAKOTA VISION SERVICES/SCHOOL FOR THE BLIND
SFN 51705 (07-2019)

ND Vision Service/School for the Blind
500 Stanford Rd.
Grand Forks, ND 58203-2799
Phone (710) 795-2700
FAX (701) 795-2727

CLIENT INFORMATION

Name of Client (Last, First, Middle Initial)		Date of Birth	
Street Address	City	State	ZIP Code

RELEASE OF CLIENT INFORMATION

I Hereby Authorize the Mutual Exchange of Information Between:

Name			Name		
Address			Address		
City	State	ZIP Code	City	State	ZIP Code

Information Requested (Select one or more as appropriate)

☐ IEP ☐ Eye Reports ☐ Vocational Records
☐ Progress Notes ☐ Educational Evaluations ☐ Psychological Notes
☐ Other (please specify)

Purpose of Disclosure

☐ Assessments ☐ Further Services
☐ IEP Planning ☐ Other (please specify)

CONSENT

1. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
2. I understand that I may cancel this authorization at anytime by submitting a written request to North Dakota Vision Services/School for the Blind, except where a disclosure has already been made in reliance on my authorization.
3. I understand that information disclosed under this authorization maybe disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.
4. If the authorized information is protected be Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
5. A photocopy of this release is as effective as the original.
6. I understand that this authorization will expire 12 months from the date of signing.
7. I understand that my name will not be used for marketing purposes.

Signature of Client	Date
Signature of Parent/Guardian	Date

DISTRIBUTION: **Original** - To agency/person from whom information is sought
Copy - Requesting agency
Copy - Client