Elizabeth Pierce Olmsted Center for the Visually Impaired Preschool
Authorization to Release Confidential Information

Students' Name _____ Date of Birth _____

Doctor's Name _____ Phone # _____

Ophthalmologist's Name/ Phone # _____

* Information may be obtained for educational or medical purposes.

I hereby authorize the release of medical/educational information from my child's records. I understand that the information is confidential and protected form disclosure. I understand that I may cancel my consent to release information at any time before it is released.

_____	_____
Signature of Witness	Signature of Parent
_____	_____
Printed name of Witness	Printed name of Parent
_____	_____
Date	Date

If you do not wish to give permission to have medical/educational information released, please check the appropriate line and sign.

___ I hereby cancel my permission to release information from my child's records.

___ I hereby refuse to authorize release of information from my child's records