# Center for Deaf and Hard of Hearing Education * Indiana Department of Health
# Authorization for Exchange of Child/Student Information/Consultation

**This form is used to exchange information regarding students. The original should be forwarded to the agency/ school releasing the information. A copy should be filed in the child/student's record file and retained for three (3) years.**

## PART I: Child/Student for Whom Information Will Be Exchanged

**Name** _____ _____ ___ _____ _____

*Last* *First* *MI* *Grade* *Date of Birth*

## PART II: Agency/School with Whom Information Will Be Exchanged

**Name** _____

**Address** _____

_____

**Phone** _____ **FAX**_____

## PART III: Records/Information Needed

_____ **Medical Evaluation/Health Records**
_____ **Medications/Treatment Issues**
_____ **Vision Information**
_____ **Audiological Information**
_____ **Other:** _____

## PART IV: Ongoing Consultation: _____ YES _____ NO

## PART V: Authorization

**I give permission for the Center for Deaf and Hard of Hearing Education to request and exchange records/information for the above child/student with the above listed agency/school. I understand this information will be used to assist in individualized family service planning or individualized education programming or in use for providing health care for my child.**

**It is also understood this authorization is valid for one calendar year from signature date. I further understand that I have the privilege of revoking this at any time, providing I submit a written notice. However, this will not affect the information released prior to revocation. I further understand that this information may be re-disclosed to other departments within Indiana School for the Deaf as deemed educationally and/or medically necessary.**

_____ _____

*Signature of Parent/ Legal Guardian (Student if over 18)* *Date*

_____ _____

*Witness to Signature (if above signed with "X" or thumbprint)* *Date*

**Send Records To:**

**Center for Deaf and Hard of Hearing Education**
**CDHHE**
**Attn: EWAC-Audiology**
**1200 East 42nd Street**
**Indianapolis, IN 46205**

**Phone: 1-855-875-5193**
**FAX: 317-550-4873**
**(HIPAA compliant fax number)**

Information Requested: _____ Information Sent/Received: _____