**RELEASE OF INFORMATION**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Attn: HKNC**

I,  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**, hereby authorize the release of my records and (print name)

information to the Helen Keller National Center, for the purpose of program information.

Information requested (please initial items requested):

**\_\_\_\_\_** Medical (including ophthalmological)

**\_\_\_\_\_** Audiological

**\_\_\_\_\_** Psycho-Social

**\_\_\_\_\_** Education

**\_\_\_\_\_** Rehabilitation Training

**\_\_\_\_\_** Employment

**\_\_\_\_\_** Financial

**\_\_\_\_\_** Psychological

**\_\_\_\_\_** IEP

**X\_** Other;  **ICanConnect files from STATE of \_\_\_\_\_\_\_\_\_\_\_**

This authorization is valid from the date of signature for a period of two years unless signer rescinds permission in writing.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Signature) (Signature Parent/Legal Guardian)(Date)

**141 Middle Neck Road Sands Point, NY 11050** **• 516 944-8900 • 516 944-8637 TTY • 516 944 7302 Fax**