Paul V. Sherlock Center
On Disabilities / Rhode Island College

600 Mt. Pleasant Ave.
Providence, RI 02908-1996
401-456-8072
TTY: 711
Fax: 401-456-8150

Rhode Island Vision Education & Services Program

Authorization for Release of Confidential Information

Date:		**Name:**_____	**DOB:**	
Address: _____			**Phone:**	
LEA/School:_____			**Grade:**	

I HEREBY AUTHORIZE THE RHODE ISLAND VISION EDUCATION AND SERVICES PROGRAM

TO: ☐ RELEASE ☐ EXCHANGE WITH ☐ OBTAIN FROM ☐ VERBALLY EXCHANGE WITH

AGENCY/SCHOOL/INDIVIDUAL

School/Agency:	_____
Address:	_____
Phone/Fax/Email:	_____

THE FOLLOWING CONFIDENTIAL INFORMATION:

☐ Academic Records	☐ Educational	☐ Social History	☐ Child Outcomes Summary Forms
☐ Medical/Health Records	☐ Psychological	☐ Clinical/Psychiatric	☐ Teacher/Therapist Notes & Observations
☐ IEP ☐ 504 Plan ☐ IFSP	☐ Speech/Language	☐ Meeting minutes	☐ Neuropsychological/Neurodevelopment
☐ Eligibility Determination Form	☐ Occupational Therapy	☐ Physical Therapy	☐ Audiological
☐ Other: _____			

FOR THE PURPOSE OF: ☐ Educational Planning ☐ Other:_____

Within the educational setting, the Family Educational Rights and Privacy Act (FERPA) govern the confidentiality and disclosure of educational records. This form is used to request the release of information to assist in providing educational programs and services to the named student. This consent will have a duration of no longer than one (1) year from the date of this form. I understand that I may withdraw my consent at any time. The revocation must be in writing and received by the Paul V. Sherlock Center on Disabilities, 600 Mt. Pleasant Avenue, Providence, RI, 02908. Therefore, I release RIVESP and its employees from all liability arising from this disclosure. I understand that a withdrawal will not apply to information already released in response to this authorization. I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign the authorization. I understand that any disclosure of information carries with it a potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

Unless otherwise directed, this release is valid through for one year from the signature date.

Signature: _____ Relationship: _____ Date: _____

Printed Name: _____