

**PERMISSION TO OBTAIN AND RELEASE INFORMATION**

**This information is entirely confidential**

To best serve your child and family, it may be necessary to obtain from and share information with other individuals or agencies who are involved with your child. Information to be shared is limited to what is necessary to enable us to work effectively with you and your child. (e.g. goals, observations, assessments, reports, etc.)

- **In order for us to request or receive information, please:**
- **Fill in this form as completely as possible**
- **Read and sign below in both boxes.**
- **Initial each service you are receiving/have received (ON BACK)**

Child: \_\_\_\_\_ Birthdate (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**I hereby give permission to obtain and release verbal or written information from the following individuals and agencies to the BC Family Hearing Resource Centre:**

\_\_\_\_\_  
Name of Legal Guardian  
(Please print)

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date (mm/dd/yy)

**In order to quickly provide information and reports to you or other professionals providing service to your child, we sometimes use email or fax. We take precautions using email and fax in an attempt to protect your privacy. However, you need to be aware that faxing or emailing information does include the risk of personal information being accidentally disclosed to other people (e.g. on the web). For this reason we need your permission to send reports through email or fax.**

\_\_\_\_ Yes, I give my permission to send reports on my child through email or fax.

\_\_\_\_ No, I do not give permission to send report on my child through email or fax. All reports must be sent through the mail.

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date (mm/dd/yy)

**This authorization will terminate 12 months from the date of most recent signature or sooner at family's request.**

**Continued on back – please turn over →**

**Child's Name:** \_\_\_\_\_

| <b>*LEGAL GUARDIAN INITIALS*</b> | <b>SERVICE</b>                          | <b>NAME/AGENCY, FULL ADDRESS &amp; PHONE NUMBER</b> |
|----------------------------------|---|---|
|                                  | Community Audiologist                   |   |
|                                  | Surrey Memorial Hospital                |   |
|                                  | Sunny Hill Health Centre                |   |
|                                  | BC Children's Hospital                  |   |
|                                  | ENT Specialist                          |   |
|                                  | Family Doctor                           |   |
|                                  | Pediatrician                            |   |
|                                  | Other Doctor                            |   |
|                                  | Infant Development                      |   |
|                                  | Supported Child Care                    |   |
|                                  | Preschool/Daycare                       |   |
|                                  | Deaf Blind Early Intervention Program   |   |
|                                  | Speech Language Pathologist             |   |
|                                  | Occupational Therapist                  |   |
|                                  | Physical Therapist                      |   |
|                                  | School District/ Prov. Resource Program |   |
|                                  | Sign Language Services                  |   |
|                                  | BC Early Hearing Program (BCEHP)        |   |
|                                  | Foster Parent                           |   |
|                                  | Other                                   |   |

**\*Please ensure each appropriate individual or agency is initialed in the left column.\***