



**The Ohio Center for Deafblind Education
Deafblind Technical Assistance Program (DBTAP)**

Parent Release to Share Information

Child's Name: _____

Parent's Name: _____

Street Address: _____

City, State, and Zip Code: _____

Phone Number: _____ Email: _____

County Of Residence: _____

I give permission for the _____ School District or Early Intervention Program (please specify) to release program and medical information about my child for use in the Technical Assistance On-Site Consultation. I also give permission for my child to be observed.

____ (Optional) By initialing here, I also agree to give consent for The Ohio Center for Deafblind Education to provide Helen Keller National Center with information regarding my child.

Signature

Date

Please return original form with signature to:

The Ohio Center for Deafblind Education
ATTN: Heather Herbster
2080 Citygate Drive
Columbus, Ohio 43219