



PARENT CONTACT AND RECORDS RELEASE

Please sign and return to NEC ASAP. Thank you

CHILD NAME: _____ DOB: _____

CURRENT ADDRESS: _____

EMAIL ADDRESS: _____ HOME PHONE: _____
PLEASE PROVIDE BE GREEN FRIENDLY

WORK PHONE: _____ CELL: _____

The staff of the New England Consortium has my permission to contact me directly concerning my child who is deafblind and regarding newsletter mailings, parent workshops, regional meetings, and other communications of general interest to parents and/or advocates and to send your child's name to the local vision/hearing agency. AND, I give my permission to the below named person/agency to release information via phone, mail or fax to the New England Consortium regarding my child's vision, hearing and/or education plan. *I understand this information is necessary for registration, will remain confidential, and is requested in order to determine eligibility for deafblind technical assistance/consultation services.

Signed:

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

EXPIRES IN ONE YEAR

PLEASE SELECT ONE BOX

 I HAVE ATTACHED THE FOLLOWING REPORTS:

- Hearing Report (Audiology) or Functional Hearing Assessment (or Dr's Summary)
- Vision Report (Ophthalmology) or Functional Vision Assessment (or Dr's Summary)

 I DO NOT HAVE HEARING OR VISION REPORTS. I AM REQUESTING YOU/NEC OBTAIN RECORDS FROM THE BELOW PERSON/AGENCY: (Parent/Guardian please complete and NEC will request records for you.)

HEARING PERSON

VISION PERSON

NAME:

COMPANY:

STREET/FLR:

CITY:

ST:

ZIP:

PLEASE MAIL RECORDS FOR THE ABOVE NAMED CHILD TO:



NEW ENGLAND CONSORTIUM (NEC)

Attn: Project Assistant

175 No. Beacon St, Watertown, MA 02472