Permission for Referral

_____ _____

Last Name First Name M.I. Date of Birth

North Carolina has several agencies that assist children with diagnosed hearing loss and their families. Each individual agency can best explain the details of the services they offer and answer questions for you as you make informed choices about accepting or declining services for your child. You have the right to accept or decline any of the services at any time. The signed Permission for Referral must be on file in order for these agencies to contact your family.

The agencies you accept will contact you to tell you more about their services. Please indicate below if you accept or decline the **referral** to each agency:

Child's Age - Birth to 3 years

BEGINNINGS for Parents of Children Who are Deaf/Hard of Hearing ☐ ACCEPT **or** ☐ DECLINE
Infant-Toddler Program ☐ ACCEPT **or** ☐ DECLINE

Child's Age – 3 years through 21 years

BEGINNINGS for Parents of Children Who are Deaf/Hard of Hearing ☐ ACCEPT **or** ☐ DECLINE
Local Education Agency (Public Schools) ☐ ACCEPT **or** ☐ DECLINE
Residential Schools for the Deaf ☐ ACCEPT **or** ☐ DECLINE

I hereby authorize _____ to release audiological evaluation results and contact
(Audiologist/Audiology Facility)
information to the North Carolina Division of Public Health for the purpose of completing referrals to the agencies accepted above. I further authorize _____ to release audiological results upon
(Audiologist/Audiology Facility)
request to the agencies accepted above for the purpose of assisting the agency to understand my child's hearing loss. I further authorize each of the above accepted agencies to release eligibility, enrollment, withdrawal, assessment, and educational plan information upon request to the North Carolina Division of Public Health for the purpose of program evaluation and coordination of care related to my child's hearing loss.

I understand the terms of this release, the need for the information, and that there are statutes and regulations protecting the confidentiality of the information. I acknowledge that this consent is voluntary and is valid until such request is fulfilled. I further understand that I may revoke my consent by giving written notice to the agency with authority to release the information, except to the extent that action based on this consent has already been taken.

_____ _____

Witness Signature of Patient, Parent, or Legally Appointed Representative

Language Spoken in Home: _____ _____

Date Signed

Phone: _____ _____

Mother's (Parent's or Guardian's) Printed Name

Alternate Phone: _____ _____

Address

Email Address: _____ _____

City, State, Zip

Child's Doctor: _____ _____

County of Residence

FAX a copy of the completed form AND audiological report AND otological clearance to:
Marcia Fort, AuD
North Carolina Division of Public Health
(919) 870-4881

Revised December 2015