Permission to Release Information

Name of Eye Doctor:______________________________

Eye Dr.'s Address:________________________________
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Eye Dr.'s Phone #:________________________________

Dear Doctors:

I give my permission for you to release information about my child's vision to representatives from the Keystone Blind Association. This information will be used to determine eligibility for services as well as to ensure that my child receives appropriate support related to his/her visual impairment. Please include the most recent information regarding my child's vision. This release form is valid for 90 days from the date below.

Thank you for your consideration in this matter.

Name of Child: ________________________________

Date of Birth:____________________

Social Security #:____________________

Address:____
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Parent/Guardian Name:______________________________

____ ____________________
parent/guardian signature date