CS-017 Authorization for Release of Information

Revised 12/16/2021

DIVISION OF BLIND SERVICES
Florida Department of Education | dbs.fldoe.org

Personal Information:

First Name:	**M.I.:**	**Last Name:**	
Date of Birth:			
Address:			
City:		**State:**	**Zip Code:**
Telephone Number:	**E-mail Address:**		

Release Information:

I authorize the Division of Blind Services **to release** information to:

Name of Provider or Facility:		
Address:		
City:	**State:**	**Zip Code:**
Telephone Number:	**Fax Number:**	

Obtain Information:

I authorize the Division of Blind Services **to obtain** information from:

Name of Provider or Facility:		
Address:		
City:	**State:**	**Zip Code:**
Telephone Number:	**Fax Number:**	

Non-Contracted Entities to Release and to Obtain Information:

This section of the release only applies to family members and non-contracted entities.

Specific List of persons or entities requesting information:

Name	Relationship	Phone Number
	(Selection)	
	(Selection)	
	(Selection)	
	(Selection)	
	(Selection)	
	(Selection)	
	(Selection)	
	(Selection)	
	(Selection)	
	(Selection)	

Purpose for Release Information:

This information will only be used for my plan of services and will not be released to anyone else without my written request. Please check all types of records authorized to be released:

☐ Medical ☐ Psychological ☐ Eye Medical ☐ Other (specify): _____

Specific Information Authorized: (select one or more as appropriate)

☐ Assessment ☐ Progress Notes ☐ Diagnostic Impression

☐ School Records ☐ Treatment Plans ☐ Treatment Summary

☐ Laboratory Test Results:

☐ Other (specify): _____

One-time Use/Disclosure:

I authorize the one-time use or disclosure of the information described above to the person, provider, organization, facility, or program(s) identified. **My authorization will expire:**

☐ When the requested information has been received.

☐ 90-days from this date:

☐ Other (specify): _____

Periodic Use/Disclosure:

I authorize the periodic use/disclosure of the information described above to the person, provider, organization, facility, or program(s) identified as often as necessary to fulfill the purpose identified in this document. **My authorization will expire**:

☐ When I am no longer receiving services from the Division of Blind Services.

☐ One year from this date:

☐ Other (specify): _____

I understand that: I may cancel this authorization at any time by submitting a written request to the Division, except where a disclosure has already been made in reliance on my prior authorization. This document may be produced in alternative formats such as Braille, large print and audiotape.

Signature of Client or Representative:	**Date:**
_____	_____

Relationship to Client (if requester is not the participant):

☐ Parent ☐ Legal Guardian ☐ Other (specify): _____