



**AUTHORIZATION TO REQUEST, SHARE OR RELEASE INFORMATION**

Name of Student:	Date of Birth:
Address:	Phone Number:
City/State/Zip:	

Information to be shared or released by:		
School Name:	Audiology Clinic/Provider:	Other Agencies:
District:	Organization:	Organization:
Address:	Address:	Address:
City/State/Zip:	City/State/Zip:	City/State/Zip:
Phone Number:	Phone Number:	Phone Number:
Email (if known):	Email (if known):	Email (if known):

Information to be shared or released to CDHL and/or Listen & Talk

All documents for Partnership project use should be sent to:

CDHL  
 611 Grand Blvd.  
 Vancouver, WA 98661  
 Attn: Judy Smith  
 Fax: 360-696-6291

- Current three-year evaluation
- Current audiogram with report
- Current IEP/504 plan
- Report cards/teacher comments
- Other (please specify): \_\_\_\_\_

Parent/Guardian Signature:	Date:
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