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 (Part C Lead Agency)	☐ ACCEPT	**or**	☐ DECLINE
EDIS (must live on a military base) Ft. Bragg/Camp LeJeune (please circle)	☐ ACCEPT	**or**	☐ DECLINE
Early Learning Sensory Support Program-Hearing Impaired	☐ ACCEPT	**or**	☐ DECLINE

Child's Age – 3 years to 21 years

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

I hereby authorize _____ to release audiological evaluation results and contact
(Audiologist/Audiology Facility)
information to the North Carolina Department of Health and Human Services for the purpose of completing referrals to the agencies accepted above. I further authorize _____ to release audiological
(Audiologist/Audiology Facility)
results upon 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 Department of Health and Human Services 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

Permission to Text: ☐ Yes ☐ No

_____
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:
EHDI
Fax (984) 236-8202 or Email ncnewbornhearing@dhhs.nc.gov