

# Permission for Referral

\_\_\_\_\_

Last Name	First Name	M.I.	Date of Birth
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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**

- |  |                                 |           |                                  |
|--|---------------------------------|-----------|----------------------------------|
| <input type="checkbox"/> BEGINNINGS for Parents of Children Who are Deaf/Hard of Hearing | <input type="checkbox"/> ACCEPT | <b>or</b> | <input type="checkbox"/> DECLINE |
| <input type="checkbox"/> Infant Toddler Program-Children's Developmental Services Agency | <input type="checkbox"/> ACCEPT | <b>or</b> | <input type="checkbox"/> DECLINE |
| <input type="checkbox"/> Early Intervention for Children Who are Deaf/Hard of Hearing    | <input type="checkbox"/> ACCEPT | <b>or</b> | <input type="checkbox"/> DECLINE |

**Child's Age - 3 years through 21 years**

- |  |                                 |           |                                  |
|--|---------------------------------|-----------|----------------------------------|
| <input type="checkbox"/> Beginnings for Parents of Children Who are Deaf/Hard of Hearing | <input type="checkbox"/> ACCEPT | <b>or</b> | <input type="checkbox"/> DECLINE |
| <input type="checkbox"/> Department of Public Instruction (Public Schools)               | <input type="checkbox"/> ACCEPT | <b>or</b> | <input type="checkbox"/> 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 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	_____ Patient, Parent, or Legally Appointed Representative
	_____ Date Signed
Language Spoken in Home: _____	_____ Mother's (Parent's or Guardian's) Printed Name
Phone: _____	_____ Address
Alternate Phone: _____	_____ City, State, Zip

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