RHODE ISLAND COLLEGE

PAUL V. SHERLOCK CENTER ON DISABILITIES

Authorization for Release of Information

I hereby authorize the Rhode Island Vision Education and Services Program to request from:

School/Agency: ______________________
____
____

the following information:

regarding: ______________________
D.O.B.: ______________________

for the purpose of: ____

Information released with this authorization will not be given, sold, transferred, or in any way relayed to any other person not specified in the consent form. The consent for release or transfer of information may be withdrawn at any future time.

Name: ____
Signature: ____
Relationship: _____________________________________
Date: ____

Name and Title of person requesting information:

____

revised 01/14

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