

PARENT CONSENT AND AGREEMENT

I authorize Sertoma Speech and Hearing Foundation of Florida, Inc. under the name Children's Hearing Help Fund to receive any medical records or treatment for _____ regarding hearing loss from the following entities:

Florida local early intervention

program: _____,

Audiologist: _____,

Child's Physician: _____,

and the

Department of Health, Children's Medical Services. I understand that the information may include the degree of hearing loss, type of hearing aids necessary to amplify the hearing loss, and progress made with amplification.

I hereby authorize Sertoma Speech and Hearing Foundation of Florida, Inc. under the name Children's Hearing Help Fund to release any audiological or related medical records regarding my child's audiological management or medical treatment of hearing conditions, to Department of Health, Children's Medical Services. I understand that my refusal to consent to this release of information will affect my child's ability to receive loaner amplification instrument(s). I agree to assume all responsibility from my refusal to exchange this information and also agree not to hold my provider or other personnel responsible for any adverse results from my refusal to release this information.

I authorize release of information to local and state agencies that allow for continuity of care for my child. This includes area school boards and early intervention providers.

I agree to accept loaner hearing aids, Model: _____, Serial Number: _____ and understand that it is my legal and financial responsibility to return these devices in the same working condition I received them. I further agree to return these hearing aids by _____, unless requested to do so sooner.

Witness

Parent/Adult Legally Responsible for Minor Child

Date Time

Date Time