

Olympic Educational Service District 114

Early Learning Department 105 National Ave N Bremerton, WA 98312 (360) 478-6887 • 1-800-201-1300 • FAX (360) 405-5808



Referral for Further Evaluation Consent Form

Authorization to Disclose the Records	of:	
Child/Participant Name:		Date of Birth:
Parent/Guardian Name:		Phone Number:
Reason for Release of Information : Referral for further developmental and/or social emotional evaluation.		
I authorize mutual exchange of information about my child, as described below, between the following organization/school district and OESD 114 Early Learning Department for the purposes of further developmental and/or social emotional evaluation and service coordination.		
□ I authorize the organization/school district to contact me to initiate the referral process for my child.		
Organization/School:		
Address:		
Phone:		Fax:
Referral is for the Following:		
 Articulation Language Development 	□ Motor Skills □ Adaptive	Social Emotional Vision
□ Cognition Documentation Attached:	Behavioral	Hearing
\Box ASQ-3	□ DECA	□ Three Prong Vision and Hearing
\Box TS Gold Assessment	□ DRDP Assessment	□ Preschool Hearing and Vision
My permission is valid for ONE CALENDAR YEAR from signature date.		
 I understand all information related to this referral will be treated in a confidential manner and will not be transmitted to a third party without my written permission. I understand that it is my right to request a copy of all information as well as to contest any information I feel is incorrect. I may revoke or withdraw my permission in writing at any time. I understand this will not affect information already disclosed. 		
Authorization Signature	Printed Name	Date
Relationship to Child	Phone Number	Organization (if applicable)
□ I/we need interpretive services in this language:		
If I am not the person who is the subject of the records, I am authorized to sign because I am the:		
\square Parent \square Legal Guardian \square Other:		