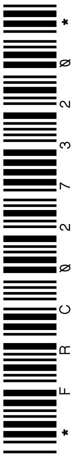

Consent – Centre CCH

UR NUMBER

SURNAME

GIVEN NAME(S)

DATE OF BIRTH

AFFIX PATIENT LABEL HERE ↑

Specialist Clinics
Centre for Community Child Health

Re______________________________________UR:____

Consent to release information

I____ parent/guardian

of my child ____ give permission for

release of information to:

- ○ family doctor, specialist
- ○ community nurse
- ○ allied health professionals - psychologist, speech pathologist, occupational therapist, other
- ○ teacher and/or appropriate school staff
- ○ preschool teacher and/or other associated staff
- ○ early childhood professional
- ○ other, please specify___________________________________

I give permission for the above to:

- ○ complete questionnaires about my child's health, development, learning and behaviour
- ○ discuss my child with Dr____
- ○ receive a copy of letters and/or reports written by Dr_______________________________ about my child

Signed ____ Date_____________________

Consent – Centre CCH MR92/C