SPEECH PATHOLOGY

ABC SPEECH PATHOLOGY
Release of Information / Consent Form

Child's Name:
Parent / caregiver Name:
Date:

I give ABC Speech Pathology permission to access information and to provide information to the following people regarding my child's speech pathology services. This will include any relevant health information and or previous assessments by speech pathologists or other health professionals.

Psychologist
Teacher
Principal
Doctor
Audiologist
Occupational therapist
Physiotherapist
Specialist
Other _____

I give ABC Speech Pathology permission to save confidential health information in my child's digital file to be accessed by the speech pathologist working with my child.

Information to be saved will include speech pathology session notes, assessments, reports, planning documents, consent forms, therapy photographs or videos and any other documents relevant to my child's treatment (eg. previous reports from other health professionals, diagnosis etc).

This information will be used for the purpose of assessment and therapy. Information will be saved into your child's confidential file and will only be shared with the relevant health professionals listed above. Your child's confidential information will be used to transition your child into / or out of our service. Access to this information will assist the therapy team to ensure continuity and consistency of care.

Signed:	
DATE:	