SUPPORT KIDS IN PAIN

Child's Name:	_____
DOB:	____/____/_____
Phone No:	_____
Address:	_____
	_____

Consent to obtain/release information

Under the Queensland *Information Privacy Act 2009*, we require your consent to collect and share personal information about your child with other health providers. Collecting this information directly from your health providers enables our team to properly assess, diagnose and treat illnesses and be pro-active in your child's health care. To continue this quality of care, we will also undertake to notify your GP and any relevant practitioners of the outcomes of your program participation.

We may also use the information you provide in the following ways:
i Administrative purposes;
i Billing purposes, including compliance with Medicare requirements;
i Disclosure to others involved in your health care, including treating doctors and specialists outside our organisation. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals. If necessary, we will discuss this with you.
i Disclosure to other allied health and medical professionals for the purpose of patient care and teaching.
Please let us know if you do not want your records accessed for these purposes, and we will note your record accordingly.

Please read this information carefully and sign where indicated below.

I …….…. (*print name*), parent/ward of…….....
(*print child's name*), provide consent for Support Kids in Pain (SKiP) to obtain information from and/or release information to the following health professionals (add additional practitioners if necessary):

GP Name (required): _____
GP Practice: _____
Address: _____
Phone: _____ **Fax**: _____
Please specify any information you DO NOT consent to have released/obtained (eg personal history):
_____
_____

Please list other health practitioners (including specialists and allied health clinicians) below:
Name: _____
Profession: Specialist GP Allied Health Other _____
Organisation: _____
Address: _____
Phone: _____ **Fax**: _____
Please specify any information you DO NOT consent to have released/obtained (eg personal history):
_____
_____

Name: _____

Profession: Specialist GP Allied Health Other _____

Organisation: _____

Address: _____

Phone: _____ **Fax**: _____

Please specify any information you DO NOT consent to have released/obtained (eg personal history):

_____

_____

Name: _____

Profession: Specialist GP Allied Health Other _____

Organisation: _____

Address: _____

Phone: _____ **Fax**: _____

Please specify any information you DO NOT consent to have released/obtained (eg personal history):

_____

_____

I have read the information above and understand the reasons why my child's information must be collected. I am also aware that this organisation has a privacy policy on handling patient information.

I have been informed and understand how this information will be used, and that this information will not be passed on to other third parties except as outlined above.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to my child.

I understand that if this information is to be used for any other purpose other than that set out above, my further consent will be obtained.

I consent to the handling of my child's information by this organisation for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signed:..... Date:.....