Eva J Harrold ABN 66 078 020 353 Speech Pathologist

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Healesville Speech Pathology

RELEASE OF INFORMATION and CONSENT FORM

Healesville Speech Pathology needs to collect information about you for the primary purpose of providing a quality service and in order to thoroughly assess, diagnose and provide therapy.

This information will also be used for:

1.The administrative purpose of running the practice; 2.Billing either directly or through an insurer or compensation agency; 3.Use within the practice if passing your case to another speech pathologist within the practice for your ongoing management; 4.Disclosure of information to your doctors, other health professionals or to teachers to facilitate communication and best possible care for you; and 5. In the case of insurance or compensation claim it may be necessary to disclose and/or collect information that affects your return to work.

To ensure the process of quality treatment provision, information about your assessment results and progress may be given to relevant other service providers, who are involved in your management. These may include your Doctor, teachers, specialists, insurers, solicitors, employers or others, but only where it is considered to be of beneflt to your progress.

I give permission for Eva Harrold to use all due care and diligence in my best interests. **I,_____, have read the above information and understand the reasons for collecting the information and the ways in which the information may be used.**

I understand that it is my choice as to what information I provide and that withholding or falsifying information might act against the best interests of my assessment and therapy progress.

I am aware that I can access my personal and treatment information on request and if necessary, correct information that I believe to be inaccurate.

I understand that if, in exceptional circumstances, access is denied for legitimate purposes, that the reasons for this and possible remedies will be made available to me.

I give permission for my child_____
to be seen by Eva Harrold of Healesville Speech Pathology.

I understand that the Practice must obtain additional consent if the information collected is to be used in any ways other than that outlined above.

Signed……..Date……