Education Low Vision Assessment Centre

Medical Release Form

Queensland Department of Education through its Education Low Vision Assessment Centre (ELVAC) provides a wide range of specialised vision assessments, support and information to assist students with vision impairment, their families and specialist support staff. In order for ELVAC to provide targeted support to your child, ELVAC is seeking your consent for information about the student's vision impairment to be requested from the child's medical or vision specialist and disclosed by the specialist to ELVAC.

Parent Consent Section

I agree to the Department of Education's ELVAC requesting and being provided with information about my child's vision impairment and the implications of this impairment, from the specialist named below in this form. This consent will continue for a 12-month period from date signed unless revoked in writing addressed to:
Education Low Vision Assessment Centre, 17 Churchill Street, WOOLLOONGABBA QLD 4102 or by email: 3140_ELVAC@eq.edu.au.

Child's name:		Child's DOB:	
Parent's name:		Parent's signature:	
Date:		AVT/Specialist Teacher VI/HOSES:	

Please provide the details of your child's specialist doctor/s (Ophthalmologist/ Paediatrician/ Neurologist); this form will be forwarded to request your child's medical records:

Specialist's name/s:			
Address/es:			
Phone:		Fax no:	
Email:			

Medical Specialist Section

This consent form allows the Department of Education through its Education Low Vision Assessment Centre (ELVAC) to communicate with the medical specialists listed in this form, including disclosing personal information to and recording personal information received from the specialists. It authorises the medical specialists to disclose the personal information and materials to ELVAC.

One of your patients has been referred to the Education Low Vision Assessment Centre. Information and assessments from the patient's medical specialist will assist educational support personnel working with this child with vision impairment.

Medical Release Form cont.

Child's name: _____ Child's DOB: _____

Child's address: _____ (Home address when seen by specialist)

_____

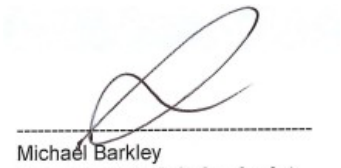
The patient attends you as a **private/public** patient at: _____

Hospital number (if applicable): _____

It would be very helpful if you could supply the diagnosis, results of investigations (e.g. ERG, CT Scan, visual fields, colour vision), level of acuity (distance and near), refractive error, prognosis and any other clinical details which you consider relevant. If cerebral vision impairment is present please note this in the report and include the major cause, if known.

Please fax to 07 3823 0757 or email to 3140_ELVAC@eq.edu.au

Yours sincerely,



Michael Barkley
Consultant Ophthalmologist

Privacy Statement

Personal information recorded on this form is being collected, used or disclosed for the purpose of the Education Low Vision Assessment Centre providing services to the identified child. The information will be kept in a secure location and will only be accessed by relevant departmental personnel. Non-identifying information may be used to contribute to quality assurance processes within the Education Low Vision Assessment Centre. Personal information recorded on this form will not be given to any other person or external body unless consent has been provided or the department is permitted or required by law to use or disclose such information.