Southwest
COLLABORATIVE SUPPORT SERVICES

CONSENT FOR SERVICE and RELEASE OF INFORMATION

Child's Name:

Date of Birth:
(yyyy-mm-dd)

Consent for Service (Please ✓ appropriate boxes)

I, on behalf of my child, consent to the involvement of the Southwest Collaborative Support Services Team (SWCSS) for the purpose of assessment (may include audio/video recording), consultation, and implementation of programming for the above named child. Indicate your consent by checking boxes for the appropriate service provider(s):

- ☐ Educational Audiologist
- ☐ Teacher for the Blind and Visually Impaired
- ☐ Teacher for the Deaf and Hard of Hearing
- ☐ Occupational Therapist
- ☐ Physiotherapist
- ☐ Speech Language Therapist

Release of Information (Please ✓ appropriate boxes)

The *Children's First Act* allows for the sharing of information between service providers in order to provide holistic care to children as long as:

- It is not contrary to the express wishes of the child and
- The service provider believes it is in the child's best interest.

I, on behalf of , give consent to the use, collection, and disclosure of personal, health, and/or educational (verbal and/or written) information for the purpose of program planning, coordination, and service delivery between the following:

Alberta Children's Hospital (ACH)	Optometrist / Ophthalmologist:
AHS Audiology & Children's Allied Health	Pediatrician:
AHS Calgary Rural Children's Rehabilitation Services	Renfrew Educational Services
Audiologist:	School Division:
Canadian National Institute for the Blind	Soundwave Hearing
ENT Specialist:	SW Collaborative Support Services Team (SWCSS)
Family Doctor:	Other:

I understand that my consent is voluntary, why I have been asked to disclose this information and I am aware of the risks and/or benefits of consenting or refusing to consent. I understand that it is my responsibility to advise SWCSS[1], in writing, of my withdrawal of any part of, or all, of this consent.

Name: _____ **Relationship:**[2] _____

Today's Date: _____

Signature: _____ **Expiry Date:** _____

(if no date, valid for 5 years)

[1] Contact: Margaret Vennard, SWCSS Program Coordinator at 403-331-9500 or margaret@swcss.ca
Office address: 3305 – 18 Avenue North, Lethbridge, AB T1H 5S1

[2] If you are not the legal guardian, please attach appropriate documentation indicating your ability to consent to services.