Children's Low Vision Project of British Columbia (CLVP-BC)

Consent For Release of Confidential Information

Student Name (First, Last)

Date of Birth

School District/Education Authority

Section A: Obtain Information

I authorize CLVP-BC and the Provincial Resource Centre for the Visually Impaired (PRCVI) to hereby **obtain** information and/or records from the following agencies or their agents:

- ☐ **Ophthalmologist**
- ☐ **Optometrist**
- ☐ **Physician/Pediatrician**
- ☐ **Teacher of Students with Visual Impairments (TSVI)**
- ☐ **Other School/District Staff Member**
- ☐ **OTHER**

Please send this completed referral as an email attachment to clvp@prcvi.org.

CLVP is hosted by the Provincial Resource Centre for the Visually Impaired (PRCVI)

PRCVI

Children's Low Vision Project of British Columbia (CLVP-BC)

Student Name: _____

Section B: Release Information

I authorize CLVP-BC and the Provincial Resource Centre for the Visually Impaired (PRCVI) to hereby **release** information and/or records to the following agencies or their agents:

- ☐ **Ophthalmologist/Optometrist**
- ☐ **Teacher of Students with Visual Impairments (TSVI)**
- ☐ **Physician/Pediatrician**
- ☐ **School/District File**
- ☐ **Ministry of Child and Family Development**
- ☐ **Community-Based Service Provider/Agency**
- ☐ **OTHER** _____
- **OTHER** _____

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PRCVI

Children's Low Vision Project of British Columbia (CLVP-BC)

Student Name: _____

AUTHORIZATION

I authorize CLVP-BC and the Provincial Resource Centre for the Visually Impaired (PRCVI) to obtain information/records for the upcoming CLVP clinic listed below from the sources listed in Section A of this form and to release information to recipients listed in Section B of this form.

Clinic Location (City/Town): _____

held on _____ (clinic date(s))

Name: _____

Relationship to Child: _____

Address: _____

City/Town: _____

Phone Number: _____

Email Address: _____

Signature: _____

Date: _____

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PRCVI