CHILDREN'S LOW VISION PROJECT OF BRITISH COLUMBIA

BRINGING COMPREHENSIVE LOW VISION ASSESSMENT SERVICE TO BRITISH COLUMBIA CHILDREN

Central Okanagan Public Schools
Together We Learn

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

STUDENT NAME _____ (Last) _____ (First)

DOB _____ (m) _____ (d) _____ (y)

SCHOOL DISTRICT _____

OBTAIN INFORMATION

1. I authorize CLVP-BC / Central Okanagan Public Schools (SD 23) to hereby **obtain** information and/or records from the following agencies or their agents:

- ☐ Ophthalmologist / Optometrist _____
- ☐ Physician / Pediatrician _____
- ☐ Vision Teacher / School District Staff _____
- ☐ Other _____

RELEASE INFORMATION

2. I authorize CLVP-BC / Central Okanagan Public Schools (SD 23) to hereby **release** information and/or records as listed below:

The CLVP-BC – Client Report is shared **on a strictly *CONFIDENTIAL* basis with:**

- ☑ Ophthalmologist / Optometrist _____
- ☑ Prov. Outreach Prog.(PRCVI) _____
- ☑ School File _____
- ☑ Vision Teacher _____
- ☐ Other _____
- ☐ Community Living Services _____
- ☐ Community Health Services _____
- ☐ Physician/Pediatrician _____
- ☐ MCFD _____

AUTHORIZATION **Please sign this form at the bottom after *Signature***

3. Obtain and/or release information: ☐ On an ongoing basis or ☐ Up to _____ (m) (d) (y)

Note: if your son/daughter transfers to another school or district, all reports will be sent to that school/district

Name _____ (please print) Relationship to Child _____

Address _____ City/Postal Code _____

Home Phone _____ Work Phone _____

Signature _____ Date _____

February 2005