EMERALD MEDICAL GROUP

Big Smiles, Little Steps — Paediatric Physiotherapy

Woo Che | Physiotherapist (B.Phty)
1 Pilot Farm Rd, Emerald QLD 4720 | 07 4986 7400
wseokche@chhealth.com.au

CONSENT TO EXCHANGE INFORMATION

Your child's privacy matters to us. This form authorises Emerald Medical Group to share and/or receive relevant clinical information with the providers you nominate, for the sole purpose of coordinating and improving your child's care. No information will be shared beyond what is necessary, and you may withdraw this consent at any time.

01 Client Details

Child's Full Name

Date of Birth

Medicare Number (if applicable)

NDIS Participant Number (if applicable)

Parent / Guardian Name

Relationship to Child

Parent / Guardian Phone

Parent / Guardian Email

Child's School

Year Level

02 Purpose of Information Exchange

Please tick all purposes that apply to this consent:

- ☐ Referral for further assessment or specialist review
- ☐ Sharing assessment reports and/or therapy plans to support coordinated care
- ☐ Communication regarding school-based therapy delivery and scheduling
- ☐ NDIS plan management, claiming, and reporting (plan managers / NDIA)
- ☐ Progress updates to support other treating practitioners
- ☐ Supporting a formal diagnosis process or paediatric referral pathway
- ☐ General coordination of care across the child's support team

Other purpose (please specify):

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03 Authorised Providers / Organisations

I authorise Emerald Medical Group to share and/or receive information with the following providers. Complete all fields that apply and indicate the direction of sharing and type of information.

Provider / Organisation 1

Name / Organisation: _____ **Role / Profession:** _____ **Phone / Email:** _____

Direction of sharing: ☐ EMG shares ☐ EMG receives ☐ Both

Type of information to be shared:

☐ Assessment report ☐ Progress notes ☐ Therapy plan

☐ Goals summary ☐ Referral letter **Other:** _____

Provider / Organisation 2

Name / Organisation: _____ **Role / Profession:** _____ **Phone / Email:** _____

Direction of sharing: ☐ EMG shares ☐ EMG receives ☐ Both

Type of information to be shared:

☐ Assessment report ☐ Progress notes ☐ Therapy plan

☐ Goals summary ☐ Referral letter **Other:** _____

Provider / Organisation 3

Name / Organisation: _____ **Role / Profession:** _____ **Phone / Email:** _____

Direction of sharing: ☐ EMG shares ☐ EMG receives ☐ Both

Type of information to be shared:

☐ Assessment report ☐ Progress notes ☐ Therapy plan

☐ Goals summary ☐ Referral letter **Other:** _____

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Provider / Organisation 4

Name / Organisation: _____ **Role / Profession:** _____ **Phone / Email:** _____

Direction of sharing: ☐ EMG shares ☐ EMG receives ☐ Both

Type of information to be shared:

☐ Assessment report ☐ Progress notes ☐ Therapy plan

☐ Goals summary ☐ Referral letter **Other:** _____

Provider / Organisation 5

Name / Organisation: _____ **Role / Profession:** _____ **Phone / Email:** _____

Direction of sharing: ☐ EMG shares ☐ EMG receives ☐ Both

Type of information to be shared:

☐ Assessment report ☐ Progress notes ☐ Therapy plan

☐ Goals summary ☐ Referral letter **Other:** _____

04 Nature of Information to Be Shared

Information shared under this consent will be limited to what is clinically relevant and necessary. It may include, but is not limited to:

- Assessment reports and findings from the paediatric motor skills assessment
- Physiotherapy therapy plans and individual goal summaries
- Progress notes and session records relevant to the stated purpose
- Referral letters to medical practitioners, specialists, or allied health professionals
- NDIS-related documentation including support plans and service delivery records
- Recommendations for school-based strategies and classroom support
- Communication records relevant to coordinating the child's care

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05 Privacy, Confidentiality & Legal Basis

Emerald Medical Group handles all personal and health information in accordance with:

- The Privacy Act 1988 (Cth) and the Australian Privacy Principles (APPs)
- The Information Privacy Act 2009 (Qld)
- The Physiotherapy Board of Australia Code of Conduct
- The National Disability Insurance Scheme Act 2013 (Cth), where NDIS services are involved

06 Duration of Consent & Your Right to Withdraw

You are always in control. This consent can be withdrawn at any time — it does not lock you into anything. We simply ask that any withdrawal be provided in writing so that we can update our records promptly.

Duration. This consent remains valid from the date of signing until withdrawn in writing, or until the treating relationship with Emerald Medical Group ends, whichever occurs first.

Withdrawal. You may withdraw consent at any time by written notice to Emerald Medical Group at wseokche@chhealth.com.au or in person at reception. Withdrawal does not affect information already lawfully shared.

Review. This consent will be reviewed annually, or earlier if services change significantly, a new provider needs to be added, or upon your request.

Specific provider removal. If you wish to remove consent for one specific provider only, please contact us and we will update this form accordingly.

07 Your Rights

- The right to access your child's personal and health information held by Emerald Medical Group
- The right to request correction of any information you believe is inaccurate, incomplete, or out of date
- The right to know what information has been shared, with whom, and for what purpose
- The right to withdraw consent at any time without penalty or impact on the quality of care provided
- The right to make a complaint if you believe your privacy has not been respected

Privacy complaints. Contact our Practice Manager at practicemanager@chhealth.com.au. If unresolved: Office of the Australian Information Commissioner (OAIC) oaic.gov.au / 1300 363 992, or the Office of the Health Ombudsman (Qld) oho.qld.gov.au.

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CONSENT TO EXCHANGE INFORMATION — SIGNATURE

Parent / Guardian Declaration & Signature

By signing below, I confirm that:

- ☐ I am the parent, guardian, or authorised representative of the child named in this form.
- ☐ I have read and understood this form and the information provided about privacy and consent.
- ☐ I voluntarily authorise Emerald Medical Group to share and/or receive information as specified above.
- ☐ I understand that I may withdraw this consent at any time by providing written notice.
- ☐ I understand this consent does not authorise sharing beyond the providers and purposes specified above.
- ☐ I understand that withdrawal of consent does not affect information already shared prior to revocation.

Parent / Guardian

Full Name:

Signature:

Date:

Physiotherapist

Full Name:

Signature:

Date:

** For children able to provide assent (generally 12 years and older), child assent is encouraged but not required.*

FOR EMG OFFICE USE ONLY — Do not complete below this line

Form received:

Received by:

Review due:

Entered in records: ☐ Yes ☐ No

Notified providers: ☐ Yes ☐ No

Scanned to file: ☐ Yes ☐ No