Sunshine Coast Eating Disorder Access Trial

Consent To Release for Treatment Team Referral

I, the undersigned, being an Adult\(^1\) Client or an Adult\(^1\) Parent/ Guardian of a Client under the age of 18 years, acknowledge that my/ my child’s details may be shared with the following organisations and/or persons:

- **Artius: Referral and Triaging Agent** acting on behalf of the CQWBSC PHN in the Sunshine Coast Eating Disorders Access Trial.
  
  I am aware that all members of this organisation sign confidentiality agreements to not disclose personal data of clients without that client’s consent.

- **The Sunshine Coast Eating Disorders Access Project Team (ONLY), The Butterfly Foundation.**
  
  I am aware that all members of this team sign confidentiality agreements to not disclose personal data of clients without that participant’s consent.

I hereby consent to having my/ my child’s relevant **Referral\(^2\)**, **Assessment\(^3\)** and **Treatment\(^4\)** data forwarded by Artius on my/ my child’s behalf to eligible **Service Providers\(^5\)** registered with the Sunshine Coast Eating Disorder Access Trial: (please tick those to which you agree and sign below)

- [ ] To treatment team members specified under my/ my child’s current Team Treatment Plan.
- [ ] To recruit treatment team members where these are required but not specified under my/ my child’s current Team Treatment Plan.
- [ ] To select treatment team members selected from recommendations put forward by Artius as the referral body acting on behalf of the CQWBSC PHN in the Sunshine Coast Eating Disorder Trial.

I declare that:

- I have had the opportunity to view a list of recommended Service Providers\(^5\), and
- I have been given adequate time to consider my choice of Service Provider/s\(^5\) before providing consent.

I understand that I am free to withdraw consent at any stage without needing to give a reason.

**CLIENT NAME:** ___________________________________________

**ADULT GUARDIAN NAME (if Client is under 18 years of age):** ___________________________________________

**ADULT CLIENT/ ADULT GUARDIAN SIGNATURE:** ___________________________________________

**DATE:** ________________

**Forward to Artius:** Fax: 07 5502 7414 or Email: SCEatingDisorderTrial@artius.com.au

Secure message delivery via Healthlinks (artiushl) and Medical Objects to Artius (Artius)

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\(^1\)Adult is defined as a person being of 18 years of age or older.

\(^2\)Referral Data is information received as part of the referral process into the Sunshine Coast Eating Disorders Access Trial ("SCEDAT"), and commonly includes (but is not limited to) information contained within the SCEDAT Open Referral Form, SCEDAT Medical Assessment Form and supporting information such as (but not limited to) pathology reports and ECG reports, and the SCEDAT Eating Questionnaire.

\(^3\)Assessment Data is information received as part of the assessment process into the Sunshine Coast Eating Disorders Access Trial ("SCEDAT"), and commonly includes (but is not limited to) relevant medical assessments (such as, but not limited to) psychological assessments (such as, but not limited to, DASS21, EDE-Q, SCEDAT Eating Questionnaire and ED-15), and case notes.

\(^4\)Treatment Data is relevant information relating to your/ your child’s medical, psychological, dietetic, and other (where relevant) treatment, and commonly includes (but is not limited to) case notes, case summaries and case conference reports.

\(^5\)Service Providers are MBS registered health practitioners registered with the Sunshine Coast Eating Disorders Access Trial, whom have evidenced a level of experience and/or training in treating Eating Disorders, and are commonly Psychologists, Social Workers, Dietitians, and Occupational Therapists.