Nebraska Sports Concussion Network

www.NebSportsConcussion.org

AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned, being the parent, or legal guardian of:

Student Name: _____ DOB: _____
hereby grants permission for the Nebraska Sports Concussion Network:

- ❑ Saint Elizabeth Regional Medical Center
- ❑ Nebraska Orthopaedic & Sports Medicine, PC
- ❑ Regional/Affiliate Sponsor: _____
- ❑ School: _____
- ❑ Test Administrator:_____
- ❑ Credentialed ImPACT Consultant: _____

to release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to the following medical or healthcare provider (primary care physician, neurologist, neuropsychologist, or other treating physician), as indicated below.

Name of parent or guardian: _____

Signature of parent or guardian: _____ Date: _____

Student's home address: _____

Parent or guardian phone numbers (please indicate preferred contact number & time if necessary):

Home: _____ Work: _____

Cell: _____ Email: _____

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of healthcare professional: _____

Name of practice or medical facility: _____

Phone number: _____ Fax number: _____

Please allow 48 hrs. for ImPACT data to be faxed.

Saint Elizabeth Regional Medical Center

Nebraska Orthopaedic and Sports Medicine, PC

Saint Francis Medical Center

Columbus Community Hospital