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 person(s), 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 person/healthcare professional: ____

Name of practice or medical facility, organizations:

____

Phone number: _________________________________ Fax number: ______________________________

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