AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: Birthdate:

Address: Telephone:

Parent's/Guardian's Name: Parent's/Guardian's Phone:

Parent's/Guardian's Address:

I have been informed that my son/daughter may have suffered a concussion. I give my permission for my child to be enrolled in the Concussion Management Program. I have been given adequate information regarding this program, and authorize members of the concussion management team to share information between themselves and my primary care provider in order to take better care of my child. The members of the concussion management team may include the coaches, athletic directors, athletic trainers, school nurses, school psychologists, team physicians and Rocky Khosla, M.D., medical director of the Concussion Management Program. I further authorize the use and sharing of data obtained on the ImPACT testing that may be done or may have already been done on my child as part of the Concussion Management Program.

AUTHORIZATION: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility Privacy Officer or their designee. I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. **This authorization expires:_____.**

If I have authorized the disclosure of my child's health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be valid as the original.

I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, but such treatment would be rendered and managed by my child's health care provider and not by the Concussion Management Team. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee will be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my child's health information, I can contact the facility Privacy Officer or their designee.

SIGNATURE:_____DATE:_____

RELATIONSHIP:_____

IDENTIFICATION: ___Drivers License#_____ __ Other ID#_____

___State ID#_____ State from_____ Expires_____

CLERK SIGNATURE: DATE: