NYSMI NEW YORK SPORTS MEDICINE INSTITUTE

Orthopedic Surgery | Physical Therapy | Concussion Care

CONSENT FOR ImPACT® TESTING, AUTHORIZATION AND RELEASE OF INFORMATION

I give my permission for (Name of child): _____

(Child's date of birth): _____

To have an ImPACT® test (Immediate Post-concussion Assessment and Cognitive Testing) administered at New York Sports Medicine Institute | Concussion Care. I understand that my child may need to be tested more than once, depending upon the results of the test, for baseline testing and/or post-injury testing, which will be kept on file with New York Sports Medicine Institute | Concussion Care and on the servers at ImPACT®.

New York Sports Medicine Institute | Concussion Care may release the ImPACT® test results to my child's primary care physician, neurologist, or other treating physician, as indicated on the Patient Information Form. I understand that general information about the test data may be provided to my child's guidance counselor and teachers, for the purposes of providing temporary academic modifications, if necessary.

Print Name of parent/guardian: _____ Relationship: _____

Signature of parent/guardian: _____ Date: _____

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