CONSENT

FOR BASELINE COGNITIVE TESTING

and

RELEASE OF INFORMATION

I give my permission for (name of child) _____,

born (date of birth) _____, to have a baseline ImPACT® (Immediate Post-Concussion Assessment and Cognitive Testing) test administered through Central Montana Medical Center. I understand that my child may need to be tested more than once, depending upon the validity of the test results. Central Montana Medical Center may release the ImPACT test results to my child's primary care physician, neurologist, or other treating physician if determined by the evaluating medical provider to be necessary, or to any licensed healthcare professional I indicate below. The school for which my child is being tested under will receive notification of VALID or INVALID test results *only*.

I voluntarily authorize the release of these test results, or information applicable to this test, to be released to the entity listed below. Testing will not be impacted, no matter if I sign this authorization or not. **If I do not sign this authorization, information regarding this test will NOT be disclosed as specified.** This authorization is valid only for this test. Once this information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.

(Please print)

☐ Affiliated School (*if applicable*) _____

☐ Physician/licensed healthcare professional _____

☐ Practice or group name _____

Phone number (if known) _____

Name of parent/guardian_____Date _____

Signature of parent/guardian_____

Witness Name / Signature _____Date _____

Parent or guardian phone numbers:

Home _____ Preferred contact number: Home Work Mobile

Work _____ Preferred time to call (if necessary): _____ am/pm

Mobile _____

Student's home address (street address, city/state/zip) _____