Consent for Cognitive Testing and Release of Information

I give my permission for _____, born on _____,
(Name Of Child) *(M/D/Y)*
to have a baseline and a post-concussion (if needed) test administered by ProAct Medical LLC. I understand that my child may need to be tested more than once, depending upon the results of the test, as compared to my child's baseline test, which will be on file at ProAct Medical.

ProAct Medical may release my baseline and a post-concussion result to my child's primary care physician, neurologist, or other treating physician upon written request and receipt of a HIPAA form.

Name of parent or guardian:_____
(please print)

Signature of parent or guardian:_____

Date:_____