SIH Rehabilitation Sports

Student's Name: _____ Student DOB:_____

Phone Number: _____ School Attending: _____

Sports Played: _____

I, _____, am the parent/guardian of the above named student and authorize SIH Rehabilitation Services, LLC to provide the following services to my child.

CONSENT TO TREAT

SIH Rehabilitation, and any attending physician, shall provide the following medical services to my child:

- Evaluate and provide assessment/diagnosis of athletic injury
- Treatment and rehabilitation

Student Signature: _____ **Date**: _____

Parent/Guardian Signature: _____ **Date**: _____

Witness: _____ **Date**: _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
SCHOOL ATHLETIC EVENTS

SIH Rehabilitation may furnish the following medical information to the coaching staff of the above listed school:

- Medical assessment of and treatment for an athletic injury
- Diagnosis, progress of treatment and rehabilitation, expected date of return to activities and any restrictions after an athletic injury
- Other: _____

This authorization expires three hundred sixty (360) days from the date of issue. I understand that I have a right to revoke this authorization at any time and for any reason, and that such revocation must be in writing and will be honored except to the extent of any action already taken on this authorization prior to revocation. I also understand that I have a right to inspect and have copied all information to be disclosed pursuant to this authorization.

I agree that a photocopy of this authorization is as valid as the original.

Student Signature: _____ **Date**: _____

Parent/Guardian Signature: _____ **Date**: _____

Witness: _____ **Date**: _____