ALLEN | ORTHOPEDICS & SPORTS MEDICINE

Information Release and Referral

Patient Name _____ **DOB:** _____ **Date:** _____

Student: ___ No ____ Yes **School Name:** _____

Sport Injury Occurred in: _____**Where did injury occur (circle):** School / Club / Other

Club or League Name: _____ **Injury:** _____

Date of Injury: _____ **Referred by (Circle):** Athletic Trainer / Physician / Coach / Other

Referral Name: _____ **Phone #:** _____

Primary Care Physician

Name: _____ **Clinic:** _____ **Phone:**_____

Parent/ Legal Guardian/ Primary Contact

Name: _____ **Relation:** _____ **Phone #** _____

(Check the box/boxes of the following that AOSM is allowed to share or discuss the patient's medical care with)

Release of Information to: Athletic Trainer ☐ Coach ☐ Nurse ☐ School Official ☐

Other: _____ ☐

I/We _____ (**parents/ Legal Guardian if above name is a minor**):

Authorize ____ the release of all medical records from Allen Orthopedics and Sports Medicine to the above-mentioned school and or school representatives as it relates to the care of my child. This includes, but not limited to: insurance, appointments, treatment plans and test results.
In the event that I am unable to accompany my child to the office for his/her evaluation or treatment, I give my permission and authorization for the above-mentioned person **(over age 18)** to obtain medical care for my child. I also authorize the providers at **Texas Health Physicians Group** to discuss or disclose information regarding any matters relating to my child's appointments, insurance, treatment, test results and medical care to that listed above. This Authorization will remain in effect until I provide written Notification to **Texas Health Physicians Group** of changes or updates.

Decline _____ All communication and release of medical information to the above-mentioned school/ organization and its representatives as it relates to my child.

_____ _____ _____

Signature (Self/Parent/Legal Guardian) **Relationship to Patient** **Date**