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Authorization for Release of Medical Information

I, the undersigned, am the parent/legal guardian	n of,
a Student-Athlete for	_High School.
I hereby authorize my child's physician and/or a information about the injury assessments and pe	,
Athletic Trainer assigned to my child's high scho	pol.
Athletic Trainer	Phone
Treating Physician / Healthcare provider	
Clinic / Facility / Practice	
Student Athlete Name	Date of Birth
Parent/Guardian Name (print)	
Parent/Guardian Signature	Date
Home/Cell Phone	Work phone

NHMI is a 501(c)(3) organization dedicated to the advancement of knowledge in musculoskeletal care and sports medicine and to promoting and providing a safe sports environment for athletes.