James A. Cervantes, M.D.
Brock R. LaSure, M.D.
Carrie Juracek, PA-C

fpadoctor.com

Print Name: ________________________________ Date of Birth: ____________________

To Be Completed by Student / Patient:

I authorize information to be released to/from:
Bellevue University Athletic Department
1000 Galvin Road South
Bellevue, NE 68005

Mark one Information to include:
( ) Today's visit only
( ) All Sports Related Information
( ) Both Sport and Non- Sport Info
( ) Financial Information/Demographics
( ) Other____________________

This statement of consent can be revoked at any time in writing before the disclosure of the information. A photocopy of this authorization shall be as valid as the original. The information used or disclosed pursuant to the authorization might be re-disclosed by the recipient and might no longer be protected by HIPPA if the recipient is not a covered entity.

Signature of Student / Patient: __________________________________ Date: _____________

** * * Physician response is requested after the patient is examined. * * **

To Be Completed by Athletic Trainer or Student

Reason for Medical Evaluation / Referral: ____
____

Physician Response:
____
____
____
____
____

Contact: Mike Livergood (office) 402-557-7057, (fax) 402-557-5407

1103 Galvin Road South, Suite G . Bellevue, NE 68005 . 402-292-1072 . Fax: 402-292-0742