Reid
Sports Medicine

REID HEALTH CONSENT FOR TREATMENT, HEALTH CARE OPERATIONS AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR THE SCHOOL YEAR 2016-17.

I _____ (print or type name) consent to the provision of care.
(Athlete's Name)

- I understand that this care may include medical treatment, special tests, exams, evaluation, treatment and rehabilitation of an injury, illness or disability that may impact my ability to participate in athletics. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.
- I understand and agree that others may assist or participate in providing care. This may include, but may not be limited to team physicians, athletic trainers, family physicians, school nurses and emergency medical personnel. As such, I understand that there will be open communication/access to the medical record, verbally, electronically, or in print, including but not limited to diagnosis, severity, playing status, plan of care, restrictions and limitations among the medical providers involved in my care. Under the direction of a certified athletic trainer, student athletic trainers may also provide care.
- I authorize Reid Health to provide information related to my care to my family/school/team physician, school nurse, coaches, athletic department personnel, school principals, EMS personnel, and such persons as needed for them to provide consultation, treatment, establish a plan of care and determine eligibility.
- I understand that release of my health record(s) will only be for the purpose stated on this form.
- I understand that the health record(s) released by Reid Health may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) Reid Health and its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- I understand that the Athletic Trainer may contact me via cell phone or text, but will not communicate confidential medical information via text.
- I understand that this Authorization is in effect from the date of the signature extending until July 31st of the year listed as school year above.
- I understand that I have the right to revoke this Authorization form at any time by sending a written request to Reid Hospital's Sports Health Manager. I understand that the revocation does not apply to any release of my health record(s) that may have taken place prior to the date the request to revoke the Authorization is received.
- I understand that the Notice of Privacy Practices document is posted in the Athletic Training Room at my school. I also understand that a copy of this Notice is available to me upon my request or by visiting the hospital's website at www.reidhealth.org

I agree to the release of information to the phone numbers, accounts and individuals listed as contacts in the Reid Sports Medicine Athlete Demographic form, but not limited to, injury occurrence, medical status, playing status and treatment plan by the following means:

_____ _____
Athlete's Signature Date / Time

_____ _____
**Parent or Guardian Signature Date / Time

**Parent or Guardian signature not necessary for College Students over the age of eighteen (18). Parent or Guardian signature is necessary for all high school students and all minors under eighteen (18) years of age and not an emancipated minor or otherwise not competent to give consent.

REID SPORTS MEDICINE ATHLETE DEMOGRAPHICS FORM

(Please Print Clearly)

Nickname _____ Gender M F DOB _____ Year in school 5 6 7 8 Fr So Jr Sr 5thYear

Primary Address _____ City _____State _____ Zip _____

Home Phone (leave blank if no home phone) _____

Parent's Cell # (____) _____ Student's Cell # (____) _____

Secondary Address_____ City _____State _____ Zip _____

Sport 1 _____ Sport 2 _____ Sport 3 _____ Sport 4 _____

By listing a person as a contact you authorize the release of medical information to that individual. List in the order you would prefer to be contacted. Check box to authorize us to leave medical information on voice mail at this phone number.

	Contact name	Relation	Home Phone	Cell Phone	Work Phone	E-Mail
1			☐ ( )	☐ ( )	☐ ( )	
2			☐ ( )	☐ ( )	☐ ( )	
3			☐ ( )	☐ ( )	☐ ( )	
4			☐ ( )	☐ ( )	☐ ( )	

Other individuals that **are** authorized to receive medical information _____

_____

Specific individuals that **are not** authorized to receive medical information (i.e. estranged family members)

_____

Medical and Environmental Allergies

_____

Important medical alerts _____

_____

Regular medications

_____

Primary Insurance provider _____ **Policy #** _____ **Group #** _____ **Policy Holder** _____

Secondary Insurance provider _____ **Policy #** _____ **Group #** _____ **Policy Holder** _____

Primary Physician _____ **Primary Dentist** _____ **Preferred Hospital Emergency Dept.** _____

Legal Name First _____ **Middle Initial** ___ **Last** _____