Allegheny Health Network

Sports Medicine

Patient Name: _____ Date:_____

Date of Birth: (xx/xx/xxxx): _____ Last 4 (Four) digits of SSN: _____

Address: _____

Phone Number: _____

Authorization for Release of Protected Health Information

I hereby authorize the Allegheny Health Network (AHN) certified athletic trainer(s) and team clinician(s) to release Protected Health Information (PHI) to: school athletic department staff, coaches, other school administrators, EMS personnel, and other persons/entities involved in school athletics for the purpose of establishing and delivering a treatment plan or determining if a student athlete qualifies for participation in school-sponsored sports activities.

The PHI I would like to have released is as follows:

☐ Release my entire chart (I understand this may include information pertaining to AIDS/HIV; mental health care; treatment for alcohol and/or drug abuse; and sexually transmitted disease).

Do not release: ☐ **AIDS/HIV** ☐ **Mental Health History** ☐ **Drug & Alcohol**

☐ Other (specifically identify exact information to be disclosed, including specific dates of service):

_____

_____

- I understand that this Authorization shall expire one (1) year from the date of signature unless otherwise specified.
- I understand that this Authorization will remain in effect if I am treated for an injury during off-season workouts within the calendar year of when I signed the Authorization.
- I understand that I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to AHN. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization.
- I understand that I am not required to sign this Authorization as condition of my obtaining treatment.
- I understand that, to extent that any recipient of this information is not a "covered entity" under HIPAA, the information may no longer be protected by law. I understand that, in these circumstances, the individual receiving this information may be permitted to re-disclose the information. I understand that my healthcare provider is not responsible should the individual receiving this information re-disclose the information.
- I am entitled to a copy of this completed Authorization upon my request.
- I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____ _____
Signature of Patient/Student Athlete Date

_____ _____
Signature of Parent, Legal Guardian or Personal Representative Date

_____ _____
Witness/Staff Member Signature Date

If signed by a Personal Representative, complete the following:

Printed Name of Personal Representative: _____

Description of authority to act for individual (include supporting documentation):
_____

Consent to Treatment by Certified Athletic Trainer(s)/Team Clinician(s)

I, _____ (printed name of parent, legally authorized representative, or student athlete, if over 18) hereby authorize Allegheny Health Network (SHN) Certified Athletic Trainer(s)/Team Clinician(s) to provide injury/illness care and prevention related to participation in student athletic programs.

I understand that others may assist or participate in providing care and establishing treatment regimens. Under the direction/supervision of a certified athletic trainer or team clinician, athletic training students and high school student aides may also assist in furnishing care.

This consent is valid for one (1) year from the date below unless otherwise specified.

I understand that this consent is subject to revocation at any time, except to the extent that AHN has already taken action in reliance upon it. A photocopy or facsimile of this consent will be considered valid

I understand that AHN's Notice of Privacy Practices can be reviewed here: https://www.ahn.org/notice-of-privacy-practices

_____
Parent, Guardian, or Student Athlete (if over 18) Signature Date Witness