PARKVIEW
ORTHO HOSPITAL

Parkview Sports Medicine

Consent to Treat

I hereby authorize medical treatment for said athlete at_____(School Name) by the athletic trainers, physicians, and staff of Parkview Ortho Performance Center d/b/a Parkview Sports Medicine. A family member can be reached at _____ in the event additional treatment or information is required. I understand that if the said athlete is seen by a physician or other provider at Parkview Sports Medicine and my insurance requires prior approval, I will be responsible for notifying the appropriate party in order to obtain approval.

Student Name_____ Student Signature _____

Mailing Address_____ City/State/Zip _____

Date_____ Student Date of Birth _____

Parent/Guardian Name_____ Parent/Guardian Signature _____

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Acknowledgement of Receipt or Declination of Notice of Privacy Practices

I acknowledge that Parkview Ortho Performance Center d/b/a Parkview Sports Medicine (PSM) has offered me a copy of its Notice of Privacy Practices. The Notice describes how Parkview may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information, and rights that I have regarding my health information. I understand that I should read it carefully. By signing this Acknowledgement, I acknowledge that I have received a copy of the Notice.

The Notice of Privacy Practices is also available at the front desk at all PSM offices and on the PSM web site at www.parkviewsportsmedicine.com. Parkview reserves the right to change the Notice at any time. I understand that I can obtain any revisions to the Notice by accessing the PSM web site, calling PSM and requesting a copy of the Notice be mailed to me or asking for one at the time of my next appointment.

Student Name_____ Student Signature _____

Parent/Guardian Name_____ Parent/Guardian Signature _____

Date _____

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Authorization for Release of Medical Information

I hereby authorize Parkview Ortho Performance Center d/b/a Parkview Sports Medicine, its physicians and providers ("PSM") to release any and all information regarding medical treatment provided to _____ (Student Name) related to any injury, illness or that otherwise concerns my physical condition and ability to participate in athletics at _____ (School Name). PSM may disclose the information to the School, its administration, coaching and athletic staff for the purpose of informing them of my playing status. I expressly authorize PSM to discuss my condition with these individuals.

If I am over 18: I also authorize PSM to release my medical information to my parent(s)/guardian(s).

I understand that I may revoke this authorization at any time by notifying PSM, in writing, of the revocation. The revocation will not affect any action already taken in reliance on this authorization. If not previously revoked, this authorization will terminate one (1) year from the earliest date set forth below.

I understand that information disclosed to the School, its administration, coaching and athletic staff pursuant to this authorization may be re-disclosed and no longer protected by federal privacy laws. PSM will not be responsible for any such further use or disclosure of the information.

I understand that PSM will not condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on whether I sign this Authorization.

A photocopy of this authorization shall be considered as valid as the original.

Student Name _____ Student Signature _____

Student Address _____

Date _____

Parent/Guardian Name_____ Parent/Guardian Signature _____

Relationship to the Student _____

Date _____

You Are Entitled To A Copy Of This Authorization

PARKVIEW
ORTHO HOSPITAL

Parkview Sports Medicine

Interview/Photographic Release

I hereby authorize Parkview Ortho Performance Center d/b/a Parkview Sports Medicine and its employees to interview, photograph and videotape _____ (Name of Athlete) while participating in athletic events, practices and other functions associated with athletics at the above identified School. I understand that the Athlete's likeness and name may be used and displayed by Parkview Sports Medicine on its website and on social media, such as Twitter. I understand that if the Athlete provides an interview, information provided in the interview may also be included on the Parkview Sports Medicine website or on social media. I hereby release Parkview Sports Medicine, its employees and affiliates from any and all liability, claims, demands and causes of action connected with the use and publication of the Athlete's likeness and other identifying information on the Parkview Sports Medicine website and social media.

Parent/Guardian Signature _____ Date _____

Student Signature _____ Date _____