

Sports Medicine

Patient Name:		Date:			
Date of Birth: (xx/xx/xx	(x):	Last 4 (Four) digits of SSN:			
Address:					
Phone Number:					
I hereby authorize the Alleg Protected Health Information personnel, and other person	gheny Health Networ on (PHI) to: school a s/entities involved in	clease of Protected Health Information (AHN) certified athletic trainer(s) athletic department staff, coaches, other school athletics for the purpose of equalifies for participation in school	and team clinician(s) to release er school administrators, EMS establishing and delivering a		
The PHI I would like to ha	ve released is as follo	DWS:			
Release my entire chart treatment for alcohol and/o		ay include information pertaining to a kually transmitted disease).	AIDS/HIV; mental health care		
Do not release:	☐ AIDS/HIV	☐ Mental Health History	☐ Drug & Alcohol		
Other (specifically ide	entify exact inform	ation to be disclosed, including sp	pecific 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	n):	
Concept to Tweetment by Cortified Athletic Trainer(c)/Teer	n Clinicion(s)	
Consent to Treatment by Certified Athletic Trainer(s)/Tear I, (printed name of parent, legally authorized repathlete, if over 18) hereby authorize Allegheny Health Network (SHN) Certified Clinician(s) to provide injury/illness care and prevention related to participation programs.	presentative, or student d Athletic Trainer(s)/Team	
I understand that others may assist or participate in providing care and establish Under the direction/supervision of a certified athletic trainer or team clinician, a 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 spec	rified.	
I understand that this consent is subject to revocation at any time, except to the already taken action in reliance upon it. A photocopy or facsimile of this conser		
I understand that AHN's Notice of Privacy Practices can be reviewed here:		