UPMC
LIFE CHANGING MEDICINE

UPMC/UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC)
CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I _____ (print or type name) consent to the provision of care. I understand that this care may include medical treatment, special tests, exams, evaluation, treatment, and rehabilitation of athletic injuries. 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 physician, school nurse, and licensed physical therapists. Under the direction of a certified athletic trainer, college/university athletic training students and high school student aides may also provide care.

I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

I understand that copies of the UPMC Notice of Privacy Practices document are available at the school, can be sent in the mail upon my request or viewed at http://www.upmc.com/HospitalsFacilities/hipaa/Pages/privacy-notice.aspx. I give UPMC and its designees permission to use my information as described in the UPMC Notice of Privacy Practices. _____ **Patient Initials**

_____ _____
Patient signature Date

_____ _____
Signature/identify on behalf of patient/relationship Date

_____ _____
Signature/identify on behalf of patient/relationship Date

For Office Use Only:

Sign here if patient failed to acknowledge receipt of Notice of Privacy Practices: _____

Reason given by patient for failure to acknowledge receipt of the Notice of Privacy Practices:

_____

UPMC
Sports Medicine

UPMC/UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC)
Authorization for Release of Protected Health Information

RELEASE OF PROTECTED HEALTH INFORMATION

- I authorize UPMC to provide information related to my care to family/school/team physicians, school nurses, coaches, athletic directors, school principals, EMS personnel, and such other persons as is necessary needed for them to provide consultation, treatment, establish a plan of care or determine whether the Athlete may resume participation in school or sports activities.
- I authorize UPMC to use my billing information for UPMC internal departmental reporting purposes.
- I authorize UPMC (including its hospitals, other entities and programs) to use medical or other information maintained on electronic information systems or stored in various forms in connection with my care, health care operations, or payment for treatment and services.
- I understand that the health record(s) released by UPMC may be re-disclosed by the facility/person that receives the record(s) and therefore (1) UPMC and its staff/employees has no responsibility or liability as a result of the re-disclosure and (2) such information may no longer be protected by federal or state privacy laws.
- I understand that this Authorization is in effect for a period of one year from the date signed by the Athlete.
- I understand that this Authorization is in effect if I am treated for an injury during off-season workouts; however, no time frame specified shall go beyond one year from the date of signature.
- I understand that I have the right to revoke this Authorization form at any time by sending a written request to UPMC at the location where the Authorization was provided.
- I understand that my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.
- I understand that I am entitled to a copy of this completed Authorization form.

AGREED

_____
Print Athlete's First and Last Name

_____ _____
Athlete/Patient Signature Date

_____ _____ _____
Parent /Guardian Signature (If Athlete is a Minor) Date Relationship