PARTICIPATION IN ATHLETIC TRAINING SERVICES

_____ _____

Name of Student Athlete **Birth Date**

_____ _____

Address **Name of School**

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Door County Medical Center to evaluate and furnish medical care and treatment as necessary through ATHLETIC TRAINING SERVICES for the above name student athlete. Additionally, I grant the athletic trainers permission to share protected health information as required in medical care situations with other healthcare providers involved in the care of the student athlete.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, do hereby acknowledge that Door County Medical Center has provided to me a copy of the organizations Notice of Privacy Practices explaining:

- **How we use and disclose your health information**
- **Your privacy rights with regard to your protected health information**
- **Our obligations to you concerning the use and disclosure of your protected health information**

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, do hereby authorize the Door County Medical Center athletic training staff to use and disclose the protected health information of the above student athlete for purposes of participation in ATHLETIC TRAINING SERVICES. Protected health information will be used by those individuals participating in Athletic Training Services as well as the school's coaching staff, athletic director, and physical education faculty involved in sporting events.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: Right to Receive Copy of This Authorization - I understand that if I agree to sign this authorization, I must be provided with a copy. Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form. If I choose not to sign this form, it may limit my ability to participate in Athletic Training Services. Right to Withdraw This Authorization – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Door County Medical Center. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good through the period of the above student's participation in the Athletic Training Services and/or the period of the student's school enrollment.

I have had an opportunity to review and understand the content of this form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF ADULT STUDENT/PARENT/LEGAL REPRESENTATIVE:

_____ _____

Signature/Relationship ***Date***