



Athletic Consent and Authorization Form

This document contains (1) a consent for Columbus Regional Hospital to initiate and provide medical treatment to your student athlete in the event of an injury or illness; (2) an acknowledgement of receipt of CRH notice of privacy practices.(3) a HIPAA authorization form; It is very important that you read and complete all of these sections and form thoroughly and sign all sections separately. If the student athlete is 18 years old or older, he or she must sign for him/herself. Parents may not sign for students who are 18 or older. Failure to follow these instructions may result in exclusion of your child from athletic programs.

Consent of Treatment

I consent to Columbus Regional initiating any medical or first aid treatment for _____ (name of student athlete) in the event of an accidental injury or illness. I understand that an attempt will be made to contact me as quickly as possible in such an event. If I cannot be reached, Columbus Regional may initiate the treatment that CRH and its personnel believe to be in the best interest of the above-named student athlete. I acknowledge that I have read this statement, have completed and provided the school with the Emergency Contact Information Sheet, and I hereby give my consent.

Signature of parent or guardian: _____ Printed: _____
Relationship: _____ Date: _____

HIPAA Authorization

I hereby authorize Columbus Regional and its personnel and/or agents, to disclose the protected health information (PHI) of (student's name) as follows: The PHI of the student that may be disclosed under this authorization includes the records of physical examinations performed by CRH to determine the student's eligibility to participate in classroom or other school sponsored activities; records of the evaluation; records and reports regarding the diagnosis and treatment of injuries which the student incurred while engaged in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the student's physical fitness to participate in school sponsored activities.

The student's PHI may be disclosed to (1) the school principal or assistant principal, athletic director, coaches, teachers, school nurses or other members of the school's administrative staff or their designees, and (2) emergency medical personnel, hospitals or any other health professional or provider who evaluates, diagnoses or treats an injury, illness or other condition incurred by the student while participating in a school sponsored activity, as necessary to:

- Evaluate the student's eligibility to participate in school sponsored activities, including but not limited to interscholastic or intramural sports programs, physical education classes or other classroom activities;
- Document the sports medicine services provided by Columbus Regional and evaluate program outcomes;
- Resolve grievances; and
- Evaluate treatment alternatives.

I understand that CRH has requested this authorization to disclose PHI so that the school, together with CRH, can make certain decisions about the student's health and ability to participate in certain classroom and school sponsored activities in accordance with the Health Information Portability and Accountability Act (HIPAA). I also understand that the student's participation in certain school sponsored activities is conditioned upon my signing this authorization. I understand that I may revoke this authorization in writing at any time prior to its expiration date, except for the extent that action has been taken by Columbus Regional in reliance to this authorization, by sending a written revocation to the Athletic Trainer or his/her designee. I understand that the PHI released may be subject to re-disclosure by any recipient and no longer protected by federal and/or state privacy laws. Expiration of Authorization: 1 year from date signed

Signature of Student(18+) /or guardian: _____ Printed: _____
Relationship: _____ Date: _____

NOTE: IF STUDENT IS 18 YEARS OR OLDER, HE/SHE MUST SIGN THIS AUTHORIZATION. IF YOUNGER THAN 18, A PARENT OR GUARDIAN MUST SIGN FOR THIS AUTHORIZATION TO BE EFFECTIVE. A STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN CERTAIN SCHOOL SPONSORED ACTIVITIES (INCLUDING BUT NOT LIMITED TO SPORTS PROGRAMS) IF THIS AUTHORIZATION IS NOT SIGNED OR IF IT IS REVOKED

Notice of Privacy Practices

Columbus Regional has prepared a detailed NOTICE OF PRIVACY PRACTICES (NPP) to help you better understand its policies in regard to the student's personal health information. You have the right to receive the NPP prior to signing this consent. The current NPP will be posted on the school's athletic training website page, on CRH website, and a hard copy can be provided upon request by asking the staff of the Athletic Trainer.

Signature of parent or guardian: _____ Printed: _____
Relationship: _____ Date: _____