



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**

Print Athlete's First And Last Name

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:
