Athlete Name (Printed) _____

Consent to Treat

I hereby authorize the sports medicine staff at OSF HealthCare to evaluate and treat my student athlete's injury/illness pursuant to their Licensure and Scope of Practice. This includes any and all reasonable and necessary preventative care, treatment, and rehabilitation for these injuries/illnesses. In addition, in the event my student athlete needs emergent treatment/care, I authorize OSF HealthCare sports medicine staff to arrange for such care, including transportation if appropriate. I understand I will be contacted as soon as possible by the OSF HealthCare sports medicine staff in the event my child has an emergent injury/illness.

Confidentiality

All of the medical documentation generated from injury evaluation(s)/treatment(s) will remain strictly confidential and will be kept secure. Only OSF HealthCare athletic training staff that is directly involved in your athlete's medical care, or their designee, will have access to this information. You may request that the information be provided to other healthcare providers by contacting the OSF HealthCare certified athletic trainer at your school.

Given the settings in which evaluation(s)/treatment(s) will be conducted (school, fields, gyms, athletic training room, etc.) as there will generally be other athletes/coaches present; there are potential threats to confidentiality. All efforts to preserve confidentiality will be made with an understanding that it is not possible to assure absolute confidentiality of your athlete's evaluation/treatment.

There are some important exceptions to confidentiality, conditions under which information may be released with or without consent. These exceptions are as follows:

1. Suspected child abuse/neglect.
2. Suspected elder abuse/neglect.
3. Suspected intentions on the part of the patient to harm him/herself or to harm another individual.

State law mandates that health professionals report the above situations to the appropriate agencies.

A court of law could subpoena the records. In such cases, you will be contacted to discuss the information requested. Every effort will be made to keep confidentiality. However, if your medical provider receives a court order to submit records, s/he is likely to have to do so in order not to break the law.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been furnished with a copy of the Notice of Privacy Practices of OSF HealthCare. The Notice of Privacy Practices provides detailed information about how OSF HealthCare may use and disclose my confidential information. I understand that OSF HealthCare has reserved a right to make changes to the privacy practices that are

described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available upon request.

Authorization Form for Release of Confidential Health Information

I hereby authorize OSF HealthCare to release to: Pontiac Township High School (or its agents)
the following information contained in the patient record of

Athlete Name (Printed) _____

The purpose of the authorization is to allow OSF HealthCare to release to the school, or its agents, such private health information as it may deem reasonable regarding the student athlete's injury/illness to include: diagnosis, treatment, rehabilitation, and management. I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that OSF HealthCare may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. I understand that information used or disclosed pursuant to this authorization is covered under a Business Associate Agreement between the School/School District and OSF HealthCare which states that both will protect the private health information of the student-athlete. I understand that this authorization is valid until it expires, unless revoked before that. I understand that I may revoke this authorization at any time by giving written notice to OSF HealthCare of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where OSF HealthCare has already relied on it to use or disclose my health information. Written revocation must be sent to OSF Healthcare. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on July 31, 2024.

Athlete Date of Birth _____

Athlete Signature_____

Date of Signature _____
When patient/athlete is a minor, Parent/Guardian signature is required.

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

Date of Signature _____

Please specify your relationship to the athlete _____

OSF Orthopedics
2500 W Reynolds St, Pontiac, IL 61764
815.844.4062 phone 815.844.4962 fax