bellinhealth

Revised 4/29/16

CORAUT

HEALTH INFORMATION DISCLOSURE AUTHORIZATION – STUDENT ATHLETE

Full Student Name (First, Middle, and Last) ☐ emancipated minor _____ Date of Birth _____

Address _____ City, State, Zip _____

Parent's Phone Number _____

Name of School attended by Student _____ Anticipated Date of Graduation (month/year) _____

AUTHORIZES: Bellin Health Licensed Athletic Trainers, Physical Therapists, and Certified Strength and Conditioning Specialists
1630 Commanche Avenue
Green Bay, WI 54313

TO RELEASE: Information concerning my health that impacts my ability to participate in sports or classroom activities. This may include information about injuries (such as, but not limited to, sprains, strains, or concussions), surgeries (such as, but not limited to, ACL reconstruction, rotator cuff repair), test results (such as, but not limited to, MRI or ImPACT results), or medica1 conditions (such as, but not limited to, asthma).

TO: Officials of the school I attend. This would include all coaching staff, athletic directors, and educational faculty (including school administrators) who are involved in my return to normal academic progression or sporting activities.

THE PURPOSE OF THE RELEASE OF THIS INFORMATION IS:

- To inform the coaching staff and/or educational faculty of my health-related limitations and abilities to continue to participate in sporting events, physical education, and classroom activities.
- To provide the coaching staff and/or educational faculty with information on how to help me safely participate in sporting events, physical education, and the academic environment.

INFORMATION RELEASE FOR CONTINUED CARE: I authorize the release of my medical information for continued medical care, in accordance with federal HIPAA laws.

EXPIRATION DATE OF THIS AUTHORIZATION: If not previously revoked, this authorization will expire on September 1 of the subsequent academic year, or upon graduation or departure from the school system, whichever occurs first.

I have had an opportunity to review and understand the content of this two-sided authorization form. By signing this form, I understand and agree with the content.

_____
Signature of person legally authorized to sign for minor student, or signature of the student if his/her age is 18 or greater (date/time)

If other, indicate relationship:
- ☐ Custodial Parent
- ☐ Court Appointed Guardian
- ☐ Health Care Agent
- ☐ Personal Representative

_____
Printed name of person signing above

I have received a copy of Bellin Health's Notice of Privacy Practices. _____ Initials

 CORAUT

REDISCLOSURE: I understand that School Faculty and/or Coaching Staff are not health care providers, and do not have to follow federal privacy standards. The health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- **Right to Receive a Copy of this Authorization:** If I agree to sign this authorization, I must be provided with a signed copy of the form.
- **Right to Refuse to Sign this Authorization:** I understand that I am under no obligation to sign this form. If I chose not to sign this form, this may limit my ability to participate in sports because coaching staff need to be made aware of student health issues that impact students' participation in athletic events.
- **Right to Withdraw this Authorization:** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Bellin Health at the address noted above. I realize that if I cancel this authorization, it will not affect disclosures of my information that have already occurred based upon my authorization.

Photocopy/fax copy is as valid as the original.

Note to the student and recipient of information: This disclosed information is protected under Federal Law titled Standards for Privacy of Individually Identifiable Health Information 45 CFR Parts 160 & 164 and by Wisconsin Statute 146.82 and 146.83. Federal regulations prohibit you from making any further disclosure of this information without specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

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CONSEN

TREATMENT CONSENT – STUDENT ATHLETE

Full Student Name ☐ emancipated minor
(First, Middle, and Last)

Date of Birth

Address

City, State, Zip

Parent's Phone Number

Name of School attended by Student

Anticipated Date of Graduation (month/year)

CONSENT TO TREATMENT: As a result of athletic/school participation, treatment may be necessary for the student. I give consent to Bellin Health Licensed Athletic Trainers, Physical Therapists, and Certified Strength and Conditioning Specialists to evaluate, treat, and manage any injuries, and activate emergency care as indicated within their scope of practice for my child named above. I also give consent to Bellin Health Licensed Athletic Trainers, Physical Therapists, and Certified Strength and Conditioning Specialists to instruct my above named son/daughter in performance enhancing or corrective exercise techniques or programs.

EXPIRATION DATE OF THIS CONSENT: If not previously revoked, this consent will expire on September 1 of the subsequent academic year, or upon graduation or departure from the school system, whichever occurs first.

I have had an opportunity to review and understand the content of this consent form. By signing this form, I understand and agree with the content.

Signature of person legally authorized to sign for minor student, or signature of the student if his/her age is 18 or greater (date/time)

Printed name of person signing above

If other, indicate relationship:

- ☐ Custodial Parent
- ☐ Court Appointed Guardian
- ☐ Health Care Agent
- ☐ Personal Representative