CONSENT FOR TREATMENT

Student Name:_____ Date of Birth:_____ Phone:_____

Address:_____ School:_____

I hereby authorize licensed athletic trainers acting on behalf of Spencer Hospital to validate and treat any injury that occurs as a result of the student's participation in athletics at the School. This includes all reasonable and necessary preventive care, treatment and rehabilitation for these injuries both at the School, at practices and Games, and for medical evaluation and treatment at the Saturday Injury Clinic offered by Spencer Hospital by an athletic trainer or contracted physician.

I understand that athletic trainers are limited in their scope of practice under state law and cannot be a substitute for or render the independent medical judgement and medical treatment available from licensed physicians.

I understand that while the School has contracted with Spencer Hospital for athletic trainer services and the availability of the Saturday Injury Clinic in Spencer, I have the right at any time to seek medical care for the Student from any physician or other medical provider. I also understand that I should obtain services beyond the scope of these athletic trainer services and Saturday Injury Clinic from medical providers of my choosing.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed and outlines my rights with respect to such information. I understand that I should read it carefully.

I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 712-264-6198, or by accessing our website at www.spencerhospital.org, or by requesting one at this office.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize Spencer Hospital (the "Hospital") to disclose to the School's athletic coaches and other appropriate administrators my protected health information created or obtained by the Hospital in the course of providing athletic trainer services and conducting an injury clinic. This disclosure is made at my request.

The Hospital may disclose any and all information which it has created or obtained regarding my care by athletic trainers and at the injury clinic.

I understand and acknowledge that:

1. I can revoke this Authorization at any time by giving my written revocation to the Hospital at the following address: Spencer Hospital, 1200 First Avenue East, Spencer, IA 51301. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this Authorization.
2. I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law.
3. Spencer Hospital may not condition future treatment on my signing this authorization. However, I understand that my refusal to sign this authorization may affect the Student's ability to participate in School athletic programs.
4. This Authorization is effective until revoked.

A photocopy or exact reproduction of this signed Authorization shall have the same force and effect as the original.

_____ _____

Printed Parent/Guardian Name Date

_____

Signature of Parent/Guardian