Medical Information Release for ’14 -’15 School Year

Athlete’s grade for ’14-’15 school year (please circle): 7th 8th 9th 10th 11th 12th

Athlete’s sport(s) for ’14-’15:_____

I/We, _____, am/are an adult student athlete (18 years or older) **or**
Parent/Guardian Name(s) or Athlete Name (if 18 y.o.)
the parent(s)/legal guardian(s) for a minor student athlete, _____, and
Student Athlete Name
understand that the school I/my/our child attend(s) is under contract with St. Rita’s Medical Center (SRMC) Sports Medicine to provide athletic training services for their student athletes.

I/we understand that health information related to me or my/our student athlete should be protected, but in order to provide the best treatment and the opportunity for a safe and quick return to athletic activities, there may be instances in which the Certified Athletic Trainer (AT) should discuss information with regard to a student athlete’s condition with others. Therefore, when injuries or medical conditions arise that require the AT’s intervention, I/we give my/our permission for any AT from SRMC Sports Medicine who is involved in my/our student athlete’s care to discuss pertinent health information including, but not limited to, the type of injury/condition, treatment, and any participation limitations, with the following individual(s) when the situation warrants: team physician (where applicable), treating physician, family physician, dentist, emergency medical personnel, coaching staff, athletic director, other AT, any health care provider or facility currently treating me/my/our student athlete, and me/us as noted below. The AT will communicate with the aforementioned individuals on an as needed basis and will use professional discretion and judgment to protect the student athlete’s Personal Health Information (PHI). This release shall provide permission for any health care provider/facility, which is currently treating, or has treated me/my/our student athlete, to release information directly to the AT as part of the continuum of care.

I/We understand that should a change be desired in the type of health information to be discussed or with whom it can be shared, the individual who initially signed this release must make the request in writing and contact the AT. (Should a student athlete become 18 years of age during the course of the school year, the now adult student athlete would be able to make these changes.) I/we also understand that verbal approval may be given directly to the AT by the parent, guardian, or adult student athlete for a specific, single episode of communication and will be documented by the AT.

Print: Adult Student Athlete _____
or
Parent/Guardian name(s) _____

Signatures: Adult Student Athlete _____ Date: _____
or
Parent(s)/Guardian(s) _____ Date: _____

Primary Contact Information:
Parent(s)/Guardian(s) contact #(s)
_____ cell: _____ home: _____
_____ cell: _____ home: _____

Secondary Contact Information:
Name(s) & contact #(s)
_____ cell: _____ home: _____
_____ cell: _____ home: _____