Athlete Legal Name (Printed): _____

Date of Birth: _____

Sports planned to participate in: _____

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 student athlete 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 which may include in the OSF electronic medical record used by the OSF HealthCare Athlete Trainers. You may request that the information be provided to other healthcare providers by contacting the OSF HealthCare certified athletic trainer at your school or OSF Orthopedics as shown below.

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 protect your 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 offered 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.

OSF Orthopedics
309.676.5546 phone 309.676.5045 fax
www.osfmedicalgroup.org

Athlete Legal Name (Printed): _____

Date of Birth: _____

Authorization Form for Release of Confidential Health Information

I hereby authorize OSF HealthCare to release to **HENRY-SENACHWINE CUSD #5** (or its agents) the following information contained in the patient record of the identified athlete above.

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 any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. 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 this authorization is valid until the expiration date entered below, unless revoked before that. I understand that I may revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to OSF Multi-Specialty Group – OSF Orthopedics. 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.

Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on July 31, 2022.

DISCLOSURE – Demographic information may be added to this form after signature for identification purposes.

Athlete Signature: _____

Date of Signature: _____

When patient/athlete is a minor, Parent/Guardian signature is required.

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____

Date of Signature: _____

Relationship to the athlete: _____

OSF Orthopedics
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