Carle

# RELEASE OF INFORMATION
# SPORTS MEDICINE

ROI

**I authorize Carle Sports Medicine to discuss / disclose medical information related to any sports injury from the medical record of:**

Patient Name:_____ Gender:_____ Date of Birth:_____ Marital Status:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Cell:_____
Preferred Language:_____ Ethnic Group:_____ Race:_____
Primary Care Provider:_____ Religion:_____

**Emergency Contact**

Name:_____
Address (if different than above):_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Cell:_____

To: School Athletic Department located at Monticello CUSD # 25 Phone Number: 217-762-8511

This authorization will remain in effect from the date of signature throughout the remainder of the current academic school year, unless otherwise specified. (I request this authorization expire:_____)

This information may be disclosed to the appropriate school personnel involved in the athletic program, (Administrator, Athletic Director, Coaches, School Nurse), as well as any medical personnel involved in the care or treatment of the above-named individual. This disclosure is for the purpose of assessing ability to participate, coordination of treatment, injury rehabilitation, prognosis and recovery from a sports injury.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and send such request to the Carle Sports Medicine, 2300 S. First Street, Champaign, IL 61820 or to Carle Health Information Management, 3310 Fields South Drive, Champaign, IL 61822. I also understand that the revocation will not apply to any information that has already been disclosed in response to this authorization. Treatment, payment, insurance enrollment or benefits eligibility cannot conditioned on the signing of this authorization.

I understand I have a right to a copy of this authorization or other information provided to the above-named school. I understand that the authorizing of this release of information is voluntary. I understand that any disclosure of information carries with it the potential risk of unauthorized disclosure. If I have any questions about this authorization, I can reach out to the departments listed above.

☐ I AUTHORIZE Carle Sports Medicine staff to disclose diagnosis and treatment information to the above-named school, and to other medical providers involved in the treatment of my (child's) athletic injury.

☐ I DO NOT AUTHORIZE Carle Sports Medicine staff to disclose diagnosis and treatment information to the above-named school staff. I understand my refusal to disclose medical information to school staff may delay my (child's) recovery. I understand it is then my responsibility to obtain necessary medical information and share it with the school. I also understand that this refusal does not constitute a refusal of treatment by Carle Sports Medicine staff, and such staff's involvement, in the school's athletic program.

Signed:_____ Date:_____

*(Student Signature required if age 18 or over)*

Signed:_____ Date:_____

*(Patent/Guardian Signature required for all communications)*

# UNIVERSAL CONSENT

Carle

☐ Carle Foundation Hospital_____
☐ Carle Physician Group_____
☐ Hoopeston Regional Health Center_____

CONSENT

*imprint*

Patient Name:_____ Date of Service:_____

MRN:_____ DOB:_____

**Throughout this document the reference to "Carle" collectively refers to Carle Foundation Hospital, Carle Physician Group and Carle Hoopeston Regional Health Center.**

Consent for Treatment - I consent to the provision of care, diagnostic procedures, laboratory testing and medical treatment as my physician(s) and/or other healthcare provider(s) deem necessary. If surgery, complex diagnostic, therapeutic procedures and/or blood or blood products are required, my Practitioner will discuss these with me and additional informed consent may be obtained. I understand that there are no warranties or guarantees regarding the services and care provided. I consent to the taking of photographs or video recordings that document conditions, treatments or procedures and understand that such images will be used for medical, scientific or teaching purposes only. Information I provide regarding religious affiliation will be available to clergy affiliated with my congregation unless I indicate otherwise to admission staff. Upon completion of testing, specimen(s) or other material(s) obtained from my procedure(s) or treatment(s) may be disposed of or retained by Carle for scientific or teaching purposes or may be used by Carle or third parties for test validation or research purposes. If my specimen(s) or other material(s) are provided to third parties, the specimen(s)/material(s) will be made anonymous and its original source no longer able to be identified.

I understand that as a teaching institution, Residents and clinical students who, unless requested otherwise, may participate in my care.

Release of Records - I understand Carle may share records, charts, x-rays, laboratory work or similar information regarding my previous medical care with other Carle entities for the purposes of my treatment. I understand this information may include records of drug/alcohol treatment, HIV/AIDS testing and/or treatment and mental health treatment. In addition, I understand Carle may release any medical records related to this medical visit to my Primary Care Physician for the purpose of providing continuity of care.

Assignment of Insurance Benefits - I authorize Carle to bill my insurance(s) directly. I authorize my insurance(s) to make payments directly to Carle for all services provided, but not exceeding the charges due.

Receipt of Notice of Privacy Practices and Patient Rights and Responsibilities - I have received and reviewed a copy of the Notice of Privacy Practices and Patient Rights and Responsibilities, made available to me as a handout or as part of the Patient Registration and Admitting Information Booklet.

Payment Agreement - I assume full responsibility for and agree to pay all costs, charges and expenses incurred by me for the medical care provided by Carle, whether as an inpatient or outpatient unless I qualify for financial assistance or charity care. If my medical insurance coverage is not sufficient to satisfy such costs, charges and expenses in full, or I do not follow guidelines of my insurer and the resulting balance is not covered, I will be fully responsible for payment of this balance.

Consent to Receive Auto-dialed Messages/Calls - I hereby consent to receive auto-dialed and/or artificial or pre-recorded message calls and/or text messages to my cellular phone number and any other telephone number that I have provided or will provide or that is available to Carle from third parties. I authorize Carle and/or their affiliates and agents, including without limitation, any account management companies, debt collectors, appointment reminder software, and/or general messaging services to use automated dialing technology and pre-recorded messages, phone calls or texts even if I am charged for the call or text under my phone plan. I agree that any such contact is not considered "unsolicited" for purposes of local, state, or federal law.

Carle

CONSENT

*imprint*

Illinois Fair Patient Billing Act (210 ILCS 88/50) - Depending on the services I receive today, I understand that I may receive separate bills for services provided by Carle Hoopeston Regional Health Center, Carle Foundation Hospital, Carle Physician Group, Christie Clinic Providers, and/or other providers outside Carle who provide health care services. Further, I understand that some health care providers may not be participating providers with the same insurance plans and networks as Carle. As a result, I understand that I may have a greater personal financial responsibility for services provided by health care professionals who are not under contract with my health plan. I understand that questions about my coverage or benefit levels should be directed to my health insurance carrier. I may contact a Customer Service Representative at (888) 712-2753 or (888) 71-Carle with any questions about my bill.

The following paragraph applies only to patients receiving services at Carle Hoopeston Regional Health Center - **I understand any physician providing medical, anesthesia, or pathology services is not an employee or agent of Carle Hoopeston Health Center UNLESS their name appears on the list of employed providers as posted. Any physician NOT appearing on the list of employed physicians is an independent, non-employed medical provider who has been granted privileges to provide medical care and treatment to his/her patients at Carle Hoopeston Regional Health Center. As such, independent, non-employed physicians are not subject to the supervision or control of Carle Hoopeston Regional Health Center. I understand independent practitioners bill separately for their services.** Patients Initials_____

I understand and acknowledge that Federal and State laws require certain medical conditions/diseases to be reported to State and/or Federal agencies. Such conditions/diseases include, but are not limited to, HIV/AIDS, tuberculosis, viral meningitis and sexually transmitted diseases.

I have read (or had read to me) and understand the above information and agree to its content.

_____ _____/_____
Signature of Patient or Authorized Person Date Time

_____ _____/_____
Signature of Witness Date Time

## Interpreter Services:

I have provided interpretation in _____ of any verbal and/or written information, including this
(type of language)
consent form, that have been provided to the patient/authorized person to consent.

Interpreter:_____ Date:_____ Time:_____
(print full name/ badge #)

Signature (or if remote source, indicate company used): _____

Discrimination is Against the Law

The Carle Foundation complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Carle Foundation does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Carle Foundation provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats)

The Carle Foundation provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

**If you need these services, contact Carle Interpreter Services at (217) 326-0340.**