

Name of Student Athlete: _____ Date of Birth: _____

Request For Treatment

My/child's school has engaged Atrium Health ("AH") to support and provide healthcare services for students, athletic staff, and others. I give permission for AH providers/athletic trainers/registered dietitians ("AH Sports Medicine Team") to provide me/ my child with care deemed appropriate by the AH Sports Medicine Team. I understand that I have the right to an explanation of the nature and purpose of any proposed procedure and other options for treatment. I understand an explanation of the risks associated with each of them in accordance with the recognized standards of medical and healthcare practice will be provided. If my child is under 18, I confirm that my child can request and receive care on their own from the AH Sports Medicine Team and I consent to the AH Sports Medicine Team providing that care. I agree the AH Sports Medicine Team may refer me/my child to an outside provider and that I/my child may engage in a separate provider-patient relationship. I/my child consent to receive services by telemedicine (using interactive audio, video, or data communications to carry out healthcare) if appropriate for my/child's condition, and I understand the risks, benefits, and alternatives of doing so.

This Request for Treatment is valid for two years from the date signed below.

Release Of Medical Information

I give permission for Atrium Health ("AH") to share my/my child's medical information related to or arising from the AH Sports Medicine Team (team physicians and medical staff, athletic trainers, and student assistant(s)) with other AH providers, independent providers, school administration and their medical provider(s), and other school sports program representatives (such as coaches and school-employed athletic trainers). In the event of an emergency, information may be shared with emergency medical personnel. I understand and agree that the AH Sports Medicine Team may use and share my/child's information to coordinate care outside of the school's athletic program. I understand that AH is providing the services under an agreement with the school system, and I agree that it may share my/my child's information with the school system, which may store information on school system platforms. Reasonable efforts will be made to protect this information. It is understood that once this information is disclosed, it is no longer protected under the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA). This Release of Medical Information will be valid for two years from the date signed below.

I understand that information disclosed by me/my child may be necessary to determine eligibility for sports. In general, a health care provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the Authorization. In this situation, however, the services provided by the AH Sports Medicine Team are being provided for the sole purpose of sharing the information with your school system and their athletic departments. Therefore, this Authorization must be signed before services of the AH Sports Medicine Team are provided, except in an emergency.

You have the right to revoke this Authorization at any time by sending a written request to the Chief Privacy Officer, Atrium Health, P.O. Box 32861, Charlotte, North Carolina 28232. Note that revocation of the Authorization does not apply to any information that was properly released under this Authorization before we received your request to revoke it. Information used or disclosed based on this Authorization may be subject to re-disclosure by the recipient and will no longer be protected by this Authorization or federal or state privacy laws. You are entitled to a copy of this Authorization.

Atrium Health Notice of Privacy Practices

We are required to make available our Notice of Privacy Practices.

[Please click HERE to see our Notice of Privacy Practices \(english\)](#)

[Please click HERE to see our Notice of Privacy Practices \(spanish\)](#)

Acknowledgement of Receipt of AH Notice of Privacy Practices

I acknowledge that the AH Notice of Privacy Practices has been made available to me and I agree that I can receive it electronically. I understand that I have the right to receive a paper copy of the Notice of Privacy Practices upon request.

I have read and agree to the above Request for Treatment and Release of Medical Information.

Printed Name of Student over 18 or Parent/Guardian_____
Student over 18 or Parent/Guardian Signature_____
Date