

Consent for Athletic Trainer Services

Please read this form. Ask questions about anything that you do not understand before you sign.

Treatment

I authorize Children's Hospital and Health System, Inc. ("Children's") Athletic Trainers and/or a Sports Medicine physician to evaluate and treat my child during school athletic events. Athletic Trainers are health care professionals trained to provide student athletes with education, evaluation, acute management and rehabilitative care for sport and physical activity related injuries and illnesses.

Benefits and Risks

Benefits may include the following:

- Timely injury evaluation
- Quicker recovery and rehabilitation outcomes due to earlier intervention
- Improved injury management and guided return to physical activity
- Early recognition and expedited referral for additional care if needed

Risks may include the following:

- Skin irritation (e.g. ankle tape), muscle soreness following recommended exercises, decreased circulation (e.g. use of compression wraps)
- Other risks identified throughout the course of services will be disclosed and discussed with you and/or your child as needed.

Patient Rights and Privacy

- The Athletic Trainers document the services provided in the Children's medical record. This means that your child's medical information may be shared with other health care providers and Children's for treatment and health care operations.
- Children's Athletic Trainers may collaborate with the school athletic directors, coaches, nurses and guidance counselors.
- Patient/Family Rights and Responsibilities information is available to you. You may request a copy. It is also available at CHW.org.
- The Joint Notice of Privacy Practices is available to you. You may request a copy or review a copy at CHW.org. You acknowledge you have reviewed a copy or have chosen to not review a copy.
- Photographs and recordings may be taken by Children's for treatment, training, or education purposes. You are not allowed to take photographs or recordings of Athletic Trainers when they are providing care to you child.

Financial

- There are no fees for services provided to your child by the Athletic Trainer in the school setting and/or during school athletic events. There may be circumstances when a referral is recommended for additional care. You are responsible for fees that may be associated with such a referral.

Communication

- I give Children's my permission to call, email or text me or my child about services or appointments at all of the telephone numbers/email addresses provided and know that this may result in charges to me from my phone or internet company.

I have read this information. I am legally able to consent. By signing this form, I give my permission for services by the Children's Athletic Trainers and agree to the terms listed above. My consent is valid until September 15th of the following year.

Patient's Name: _____ **Patient's Date of Birth:** _____ **Sport (s):** _____

Parent/Guardian Name: _____ **Relationship to Patient:** _____

Parent/Guardian Signature: _____ **Date:** _____



Authorization for the Use or Disclosure of Protected Health Information (Verbal Exchange and/or Medical Records)

PATIENT LABEL OR

MRN: _____

1. PATIENT INFORMATION:

Form fields for Patient Information: Last Name, MI, First, Date of Birth, Address, City, State, Zip, Cell Phone, Home Phone, Email.

2. I AUTHORIZE INFORMATION TO BE RELEASED FROM:

3. INFORMATION WILL BE GIVEN TO/EXCHANGED WITH:

Form for authorization details: Release from (Children's Hospital of Wisconsin, etc.) and Information given to (School District of Waukesha Coaches/School personnel, etc.).

4. REASON INFORMATION IS NEEDED: (Copy fees may apply)

- Reasons for information needed: Ongoing Medical Care, Personal Use, Legal Investigation, Referral, Insurance Eligibility/Benefits, School Use, Other.

5. VERBAL EXCHANGE OF INFORMATION CHECK THIS BOX TO ALLOW VERBAL COMMUNICATIONS AMONG THOSE INDICATED ABOVE

NOTE- If only allowing verbal communication and NO medical records should be sent, skip to number 7

6. MEDICAL RECORD INFORMATION TO BE RELEASED: (See back for important tips):

- Medical record information to be released: Clinic Records, Inpatient Hospital Records, Radiology Films, etc.

7. I DO NOT WANT THE FOLLOWING INFORMATION RELEASED OR DISCUSSED: (as defined by applicable state and federal laws)

- Information not to be released: Mental Health, Sexually Transmitted Diseases, HIV Test Results, Genetics, Alcohol/Drug Treatment, Other.

8. HOW INFORMATION WILL BE RELEASED:

Check One: Verbal, Paper, MyChart.

IF PAPER OR ELECTRONIC, RELEASED BY: MEDICAL RECORDS, OTHER (specify):

Release By: US Mail, Pick Up, Fax (only to healthcare organizations):

Person allowed to pick up records if other then the person listed above in Number 3

Name Relationship

9. EXPIRATION DATE:

This Authorization is valid until the following date/event: (not to exceed 3 years): If no date is listed, this authorization is good for three (3) years from the date signed below.

10. PLEASE SEE BACK SIDE OF THIS FORM BEFORE SIGNING FOR MORE INFORMATION.

I have read, understand and agree to the information above and on the back of this form, I authorize the release of my/the child's Patient Health Information.

Patient, Parent or Legal Guardian Signature Date Parent - I declare that I am the above named minor child's guardian. Self Legal Guardian (must provide paperwork) Other (please list):

11. STAFF: Date:

Please see back side of this form to find out when a witness is needed to sign the form.

FINAL RELEASE OF RECORDS IS AT DISCRETION OF THE MEDICAL RECORD DEPARTMENT.



**ADDITIONAL INFORMATION REGARDING THE RELEASE OF
MEDICAL RECORD INFORMATION FROM CHILDREN'S HEALTH SYSTEM****PLEASE READ THE FOLLOWING BEFORE VOLUNTARILY SIGNING THE FRONT OF THIS RELEASE FORM.**

All of Children's Hospital and Health System (CHHS) entities respect the patient's right to privacy of confidential medical information. I have had an opportunity to review and understand the content of both sides of this form.

Disclosure (release) of information.

Federal and Wisconsin Confidentiality laws protect this information. The laws forbid this information to be re-released unless:

- The person whose information it is gives written consent, or
- Otherwise permitted by law

I understand that the person receiving this information (recipient) might re-release this information. If this happens, the information may not be protected by the state and Federal laws anymore.

RIGHT TO REFUSE TO SIGN

I understand that this authorization is voluntary and that I can refuse to sign it. Treatment, payment or enrollment in a health care plan will not be affected if you refuse to sign.

REVOCACTION

I understand that I have the right to revoke this authorization at anytime. I must do so by submitting my revocation in writing to the Medical Record Department. My revocation will not apply to confidential information that has already been released in response to this or another Disclosure form.

LIABILITY

All CHHS entities, employees, officers and attending physicians are released from legal responsibility or liability for the release of information as indicated on this form.

VALIDITY OF FORMS

A photocopy or facsimile (fax) of this Disclosure Form is as valid as the original.

ORIGINAL PATHOLOGY SLIDES

In certain circumstances, pathology slides/specimens are loaned out to other Health Care professionals. These slides/specimens must also be returned within 30 days of send out by the laboratory department.

STAFF SIGNATURE: A staff signature is required on form if:

- The parent or legal guardian is unable to sign, or can only make a mark.
- A minor with legal rights requests the information.
- If staff is assisting the patient or family in the completion of the form.
- Other times when it is decided that a witness is needed.

IMPORTANT TIPS: For each numbered area on the form:

- #1- Print and be sure to include the date of birth of the patient.
- #2- Be specific about which site you want records to be released from.
- #3- If releasing to a doctor, include the hospital or facility.
- #4- If military request, place the reason under Other.
- #5- Fill in if authorizing verbal communications.
- #6- Be specific regarding the medical records to be released.
- #7- If you do not want specific information released, you must check a box to not include these.
- #8- Choose how the information is to be released.
- #9- This authorization will be valid for three years, unless another date is indicated.
- #10- Be sure to sign and date the form.

- If you need assistance in filling out the form, please contact the Medical Record Department at 414-266-2301. You can also fax the form to 414-266-6316 or email it to MedicalRecords@chw.org
- Be sure the form is filled out completely to ensure prompt processing.

