

# INSTITUTE For ATHLETIC MEDICINE

*Specialists in Orthopedic and Sports Rehabilitation*

A service of Fairview and North Memorial

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## ATHLETIC TRAINER CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Student Athlete Name \_\_\_\_\_ Sport \_\_\_\_\_  
(Please print clearly)

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_  
(Optional)

Phone Numbers (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

I understand that the school staffs a certified athletic trainer through the Fairview Health Services Institute for Athletic Medicine for the purposes of education student-athletes and preventing and treating injuries to student-athletes while participating in school-related events and programs during the school year.

**I consent to the athletic trainer treating injuries and authorize the athletic trainer to discuss those injuries with and release any applicable medical information or records relating to those injuries to coaches, school staff, scouts and other qualified health care providers as deemed necessary within their scope of practice. Additionally, I authorize the athletic trainer to post sign-in-sheets in the training facility or in any other area where sign-in-sheets are normally kept, which state my name, date of injury and treatment realizing that other students, staff or others may view that information.**

**I further understand that in the case of injury or illness requiring transportation to a health care facility, that a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be transported via ambulance to the nearest hospital.**

Other Information:

- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here: \_\_\_\_\_. The expiration period noted here may exceed one year only in certain situations as specified by law.
- I understand that once information is released pursuant to this authorization, Fairview Health Services doing business as Institute of Athletic medicine can not prevent the re-disclosure to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid. A copy that has not been altered will be considered as valid as an original.
- Fairview will not condition treatment on my signing this authorization.
- I acknowledge that I have received a copy of Fairview's Notice of Privacy Practices and I understand that Fairview Health Services "Notice of Privacy Practices" may be reviewed on Fairview Health Services web page at <http://www.fairview.org/privacy/> and choose "Notice of Privacy Practices-Fairview Provider."

I have read this form and understand its contents at this date and time.

\_\_\_\_\_  
Signature of Patient/Authorized Person  
(If authorized person is signing, please also print name.)

\_\_\_\_\_  
Authorized Person's authority to sign.  
(Parent, guardian, power of attorney, etc.)

\_\_\_\_\_  
Date

REASON PATIENT IS UNABLE TO SIGN \_\_\_ Minor \_\_\_ Disability \_\_\_ Other \_\_\_\_\_