PREVEA
Sports Medicine

Authorization

Purpose: This form is used for an individual to authorize use or disclosure of the individual's protected health information for the purposes stated.

Section A: Student Information

Name: _____ Date of Birth: _____

Address: _____ School: _____

City, State Zip: _____ Phone: _____

Section B: Consent to Treat

As a result of athletic/school participation, medical treatment may be necessary and I give consent to the Licensed Athletic Trainers from Prevea Health to evaluate, treat any injuries and activate emergency care as indicated within their scope of practice for my son/daughter.

Section C: Injury Information Release

I understand that as my child participates in activities, the Licensed Athletic Trainers from Prevea Health may deem it necessary to inform the coach, physical education teacher or athletic director about my son or daughter's condition/injury. By signing this form, I agree to allow the Licensed Athletic Trainers to inform the coaches, physical education teacher and athletic director of the medical condition or injury pertaining to my son/daughter. I understand that should I have a potential concern about a medical condition/injury that I do not want discussed with the people stated above, I will need to inform the Athletic Trainer. If I wish this information to be discussed with any other people, I need to directly inform the Athletic Trainer.

Section D: Expiration and Revocation

This authorization will expire (complete one)

___ On _____ / _____ / _____

___ Until I choose to revoke it

Right to Revoke: You may revoke this authorization at any time by providing verbal or written notice of revocation to Prevea Health by calling (920) 496-4700 or sending it to Prevea Health, Attn: Privacy Official, 2502 S. Ashland Ave., Green Bay, WI 54304. Revocation of this authorization will not affect any action we took in reliance on this authorization before we received your verbal or written notice of revocation.

Parent/Guardian Signature (If athlete is under 18 years of age)

I, _____, have had full opportunity to read and consider the
(Print name of Parent/Guardian)
contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my child's protected health information, as described in this form.

Parent/Guardian Signature: _____ Date: _____

Student Athlete's Signature (If athlete is 18 years of age)

I, _____, have had full opportunity to read and consider the
(Print name of Athlete)
contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Student Athlete's Signature: _____ Date: _____

Verbal Authorization:

_____

_____

_____

_____

_____

_____

You are entitled to a copy of this authorization form after you sign it.
Include this authorization in the individual's records.

I understand that a copy of Prevea Clinic's Privacy Practices can be obtained by calling (920) 496-4700 or mailing a request to Prevea Health, Attn: Privacy Official, 2502 S. Ashland Ave., Green Bay, WI 54304.