PATIENT LABEL AREA

St Luke's
UNIVERSITY HEALTH NETWORK

SPORTS MEDICINE AND ORTHOPEDIC CARE
CONSENT TO TREAT–YOUTH

CONSENT TO TREAT

I am the parent/legal guardian of the child named below. I permit St. Luke's University Health Network and its personnel to deliver health care and treatment to my child at _____ **(name of school district/program)** (the "Program") practice and games by appropriately qualified health care providers (athletic trainers, physical therapists, physicians, etc.). Such health care and treatment may include providing first aid and initial management of injuries, rehabilitation, musculoskeletal screening, evaluation and referral of injuries and management of injuries as may be deemed necessary or advisable by St. Luke's personnel in the treatment and diagnosis of my child.

I understand that this consent will remain in effect until my child ceases to be a member of the Program or until this consent is revoked by me by sending a written notification to St. Luke's, 1441 Schoenersville Road, Bethlehem, PA 18018, Attention: Senior Network Administrator, Sports Medicine Relationships.

FREE CHOICE OF PROVIDER

Nothing contained in this consent form shall in any way require or suggest that a child shall be required to seek care with St. Luke's, any Physician, or any affiliate of St. Luke's at any time whatsoever. Families are free to seek care for any injury/illness at any hospital, health care facility, provider, or physician. Nothing contained in this consent is intended to require and nothing herein shall be construed to require the family or the Program to make or influence referrals to, or otherwise generate business for, St. Luke's, any Physician, or any affiliate of St. Luke's.

Child's Name: _____ **Date of Birth:** _____

_____ **Relationship:** _____

Parent / Legal Guardian Name (*print*)

_____

Parent / Legal Guardian Address: (*print*)

City: _____ State: _____ Zip: _____

Parent/Legal Guardian Emergency Contact Number (First): _____ – _____ – _____

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

PATIENT LABEL AREA

St Luke's
UNIVERSITY HEALTH NETWORK

HIPAA PRIVACY AUTHORIZATION FORM
SPORTS MEDICINE–YOUTH

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization to Disclose.** I authorize St. Luke's University Health Network and its affiliates ("St. Luke's") to use and disclose to _____ **(name of school district/ program)** (the "Program") health information about my child obtained by St. Luke's in providing health services to my child during participation in sports programs (practices and games). The health information to be disclosed includes any information that is relevant to my child's ability to participate in practices, games, and other sports-related activities.
2. **Purpose.** The purposes of such uses and disclosures may include communicating with my child's coaches, administrative staff, athletic trainers, school nurses, guidance counselors and other individuals that are affiliated with the Program about my child's: (i) prognosis and recommended activities following an injury; (ii) ability to participate in training, practices, games and other team activities; and (iii) other health-related matters related to my child's activity with the Program.
3. **Refusal to Sign.** I understand that I may refuse to sign this authorization. St. Luke's may not refuse to treat my child based on my refusal to sign this Authorization.
4. **Expiration of Authorization.** This Authorization shall be in force and effect for as long as my child participates in the Program. This Authorization will expire when my child is no longer in the Program. After this Authorization expires, St. Luke's may no longer use or disclose my child's health information for the purposes listed in this Authorization unless I sign a new Authorization. However, materials that were created prior to the expiration of this Authorization may continue to be used or disclosed for the purposes listed in this Authorization.
5. **Revocation of Authorization.** I understand that I may revoke this authorization at any time, in writing, except to the extent that St. Luke's has already relied on it in making a disclosure. If I wish to revoke this Authorization, I will send a written request to: St. Luke's Sports Medicine, 1441 Schoenersville Road, Bethlehem, PA 18018, Attention: Senior Director, Sports Medicine Relationships.
6. **Further Disclosure.** I understand that my child's health information is protected by a federal law known as HIPAA for as long as that information is maintained by St. Luke's. If I permit St. Luke's to disclose my child's health information by signing this Authorization, that health information will no longer be protected by HIPAA. The recipient of my child's health information (the Program) might re-disclose the health information it receives, but would be required to comply with privacy laws governing schools prior to any such re-disclosure.

_____ _____
Parent or Legal Guardian Signature Date

_____ _____
Parent or Guardian Printed Name Child's Name

_____
Relationship to Child