# CONSENT TO TREAT AND AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

School: _____

Athlete Name: _____ DOB: _____
Last First Middle

Contact Information (Emergency and Non-Emergency)

1. Name: _____ Relation to Athlete: _____

   Cell: _____ Home: _____ Work: _____

2. Name: _____ Relation to Athlete: _____

   Cell: _____ Home: _____ Work: _____

The athlete/parent/guardian is aware that on-site athletic training services for the above named school will be provided by Floyd Medical Center ("Floyd"). By providing my signature below, consent to treatment is hereby granted to Floyd to provide athletic training services for sports-related injuries in the form of evaluation, management and rehabilitation or emergency referrals to appropriate health care providers if further treatment or evaluation is deemed necessary.

The athlete/parent/guardian hereby authorizes the school/Floyd athletic trainers to release my protected health information to athletic coaches and staff, other health care providers and, when necessary, to school administrators for the purposes of injury/illness information, play and participation status and return to play status.

In addition, authorization is given to Floyd athletic trainers to obtain from other health care providers any related medical information regarding any injury or illness for which the athletic trainers will be involved in the care and treatment.

All medical records will be maintained and stored by the above named school. Requests for medical information should be directed to the school.

_____
Signature of Athlete (if over 18)/Parent/Guardian

Date _____