

ST. VINCENT SPORTS MEDICINE
Consent for Athletic Training Services

Student Name: (full legal name) _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell: _____ Email: _____

Birth Date: _____ Age: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Cell: _____ Other: _____

I, _____, do hereby consent to receiving athletic training services from St. Vincent Sports Medicine. I understand that during the course of these services certain health information related to Student's athletic training services may be used and/or disclosed for treatment, payment or healthcare operations purposes, or as otherwise required by law.

I further consent to certain health information being disclosed to school personnel, including but not limited to, coaches, school administration, and/or staff, as necessary.

Further, I **CONSENT /DO NOT CONSENT (Circle One)** to information related to the athletic training services being disclosed to my parents/guardians/family members, as requested.

I understand this consent is subject to my revocation at any time, except to the extent that action has been taken in reliance on this consent. Otherwise, this consent shall expire at the end of the school year or the Student's current athletic season, whichever is later.

Athlete Signature

Date