St Luke's
Orthopaedic Specialists

St Luke's
Sports Medicine

Consent to Treat Patient

St. Luke's University Health Network: Sports Medicine Relationships

CONSENT TO TREAT:

I am the parent/legal guardian of the child named below and have the legal right to consent to permit St. Luke's University Health Network and its personnel to deliver health care and treatment to my child at _____ ("Program") practices and games by its athletic trainers, physical therapists and physicians. Such health care and treatment may include medical evaluation of injuries, administration of first aid for athletic injuries, and providing initial treatment 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 Director, Sports Medicine Relationships.

Child's Name: _____ Date of Birth: _____

LIMITATIONS:

Identify any specific limitations or exclusions for which this consent is given. (If none, state "none".)

_____

Parent/Legal Guardian Name (print) _____

Relationship: _____

Parent/Legal Guardian Address:

_____

City: _____ State: _____ Zip: _____

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

Parent/Legal Guardian Emergency Contact Number (Second): _____ - _____ - _____

Parent/Legal Guardian Signature: _____ Date: _____

St. Luke's University Health Network
HIPAA Privacy Authorization Form
Sports Medicine

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 _____ ("Program") health information about my child obtained by St. Luke's in providing health services to my child during participation in practices and games. The purposes of such uses and disclosures may include communicating with the Program's coaches and team/organization administrative staff. athletic trainers. school nurse. guidance counselor 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 matters related to my child's activities with the Program.

   I understand and authorize the release of medical records. including all diagnostic images and other medical reports, except as noted below:

   EXCEPTION: I do not give permission to release (please specify):

   _____

   _____ _____

2. **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.

3. **Expiration of Authorization.** This Authorization shall be in force and effect for a period of one year from the date this form is signed. at which time this Authorization expires. Once this Authorization has expired. 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.

4. **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. 1441 Schoenersville Road. Bethlehem. PA 18018. Attention: Senior Director. Sports Medicine Relationships.

5. **Further Disclosure.** I understand that information used or disclosed pursuant to this Authorization may be further reproduced. copied or disclosed by those who receive or view the information. and the laws governing patient privacy may no longer protect the information.

X_____ _____
Signature of parent or legal guardian Date

_____ _____
Printed name of parent or guardian and His her relationship to child

Child's name