Allegheny Health Network

Sports Medicine

Patient Name: _____ Date:_____

Date of Birth: (xx/xx/xxxx) : _____ Last 4 (Four) digits of SSN: _____

Address: _____

Phone Number: _____ Fax Number: _____

## Authorization for Release of Protected Health Information

I hereby authorize the West Penn Allegheny Health System, Inc. – Allegheny General Hospital certified athletic trainer(s) and team physician(s) to release my Protected Health Information (PHI):

Please choose who will receive the information and the method of delivery. Be certain that information is accurate and complete. Incomplete authorizations are invalid.

☐ School Administration, Athletic Directors, Secretaries, Nurses and Coaches (if student), and parent (if student is 18 or older):

The PHI I would like to have released is as follows:

☐ Release my entire chart (I understand that information may include acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus; mental health care; treatment for alcohol and/or drug abuse; and sexually transmitted disease unless otherwise indicated).

**Do not release:** ☐ **AIDS/HIV** ☐ **Mental Health History** ☐ **Drug & Alcohol**

☐ Other (specifically identify exact information to be disclosed, including specific dates of service):

_____

- I understand that this Authorization shall expire one (1) year from the date of signature unless otherwise specified below.
- I understand that I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this Authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization.
- I understand that I am not required to sign this Authorization as condition of my obtaining treatment.
- I understand that, to extent that any recipient of this information, as identified above, is not a "covered entity" under Federal Law, the information may no longer be protected by federal and state law. I understand that, in these circumstances, the individual receiving this information may be permitted to re-disclose the information. I understand that my healthcare provider is not responsible should the individual receiving this information re-disclose the information.
- I am entitled to a copy of this completed Authorization upon my request.
- I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent, Legal Guardian or Authorized Representative Date

_____ _____
Witness/Staff Member Signature Date

If signed by an Authorized Representative, complete the following:
Printed Name of Personal Representative: _____
Description of Authority to act for individual: _____

**Oral Authorization**
Only to be used if patient is physically unable to sign. This is NOT applicable to HIV related information or Drug & Alcohol Treatment.
I witness that the nature of this release has been explained to the patient, that the patient understood the nature of the release and freely gave oral authorization (two witnesses are required).
Witness: _____ Witness: _____
Date: _____ Date: _____

Allegheny Health Network

Sports Medicine

## Authorization for Consent of Treatment, by Licensed Athletic Trainer(s)/Team Physicians, Within the Scope of Practice

I, _____ (printed name of parent, legally authorized representative, or athlete if over 18) hereby authorize West Penn Allegheny Health System, Inc. – Allegheny General Hospital (AGH)Certified Athletic Trainer(s)/Team Physicians to provide only those services they are qualified through education or experience and which is allowed by their practice acts and other pertinent regulation.

This authorization is valid for 1 calendar year from the date below.

I understand that this authorization is subject to revocation at any time, except to the extent that West Penn Allegheny Health System, Inc. – Allegheny General Hospital has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing to AGH (1307 Federal Street, Suite 500, Pittsburgh, PA 15212).

Parent, Guardian, or Athlete (if over 18) Signature Date Witness