PARKVIEW
ORTHO HOSPITAL

Parkview Sports Medicine

Athlete's Printed Name	Printed Name of Parent or Guardian
Street Address	Street Address
City, State, Zip	City, State, Zip
Phone Number Email Address	Phone Number Email Address

Consent to Treat and Provide Athletic Training and Sports Performance Services

I hereby authorize the athletic trainers, physicians, and qualified providers of Parkview Sports Medicine ("PSM") to provide athletic training, and to evaluate and/or provide medical treatment, within the scope of their practices, to the athlete named above. In the event the athlete is injured, PSM will make reasonable efforts to contact a family member at this number:____if additional evaluation, treatment, or information is needed. I understand that PSM does not obtain prior insurance pre-certification or authorization and that I will be responsible for obtaining such authorization or pre-certification, if necessary.

Interview/Photographic Release

I hereby authorize PSM and its employees to interview, photograph, and videotape the athlete named above while participating in athletic events, practices, and other functions associated with athletics Club or School named above. I understand that the Athlete's likeness or name may be used and displayed by PSM on its website and on social media. I understand that if the Athlete provides an interview, information provided in the interview may also be included on the PSM website or on social media. I hereby release Parkview Sports Medicine, its employees and affiliates from any and all liability, claims, demands and causes of action connected with the use and publication of the Athlete's likeness and identifying information on the PSM website and social media. If I do not agree to this Release, I will strike it (cross it out).

Acknowledgement of Receipt or Declination of Notice of Privacy Practices

I acknowledge PSM has offered me a copy of its Notice of Privacy Practices ("Notice"). The Notice describes how PSM may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information, and rights that I have regarding my health information. I understand that I should read it carefully. My signature, below, indicates that I have either been offered or have received a copy of the Notice.

The Notice of Privacy Practices is also available at the front desk at all PSM offices and on the PSM web site at www.parkviewsportsmedicine.com. Parkview reserves the right to change the Notice at any time. I understand that I can obtain any revisions to the Notice by accessing the PSM web site or by calling PSM and requesting a copy of the Notice be mailed to me.

Release and Waiver of Liability for Athletic Training and Sports Performance Services

I voluntarily accept and assume all risk of participating in the athletic training and receiving sport performance services of PSM. I understand that such activities may expose me to associated risks of injury or even death, and I accept such risks.

I understand and acknowledge that I will engage in various physical activities designed to promote fitness. I hereby confirm that I have consulted with a duly licensed physician and have described to such physician the type of fitness program I am to participate in and have such physician's approval to participate. I further understand that any questions or concerns that I may have related to my ability to participate in physical activities should be discussed with my physician prior to participation.

As a condition of participation, I agree to hold PSM, its affiliates, assigns, officers, employees, directors, agents, licensees, consultants and independent contractors harmless of any liability resulting from any injury or other harm that may occur in, result from, or arise out of participation in such fitness activities, including any bodily injury or other harm that may result from PSM's own negligence.

Marketing Materials

I hereby consent to receive communication from PSM regarding its services, including marketing/promotional.

I HAVE READ AND UNDERSTOOD THIS TWO-PAGE AGREEMENT IN ITS ENTIRETY. I HAVE CROSSED OUT ANY TERMS WITH WHICH I CANNOT AGREE. I UNDERSTAND THAT BY MAKING AND SIGNING THIS AGREEMENT, I SURRENDER AND HEREBY WAIVE VALUABLE RIGHTS THAT I MAY HAVE, INCLUDING, BUT NOT LIMITED TO, MY RIGHT TO SUE. I DO SO FREELY AND VOLUNTARILY.

____

Printed Name of Athlete if 18 or over or Parent or Guardian (if Athlete is under 18)

____

Signature of Athlete if 18 or over or Parent or Guardian (if Athlete is under 18)

____

Date

A photocopy of this authorization shall be considered as valid as the original.

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Authorization for Release of Medical Information

______________________________	______________________________
Athlete's Printed Name	Printed Name of Parent or Guardian
______________________________	______________________________
Street Address	Street Address
______________________________	______________________________
City, State, Zip	City, State, Zip
______________________________	______________________________
Phone Number	Phone Number

I hereby authorize Parkview Ortho Performance Center d/b/a Parkview Sports Medicine, its athletic trainers, physicians and providers ("PSM") to release any and all information regarding medical treatment provided to the above named Athlete concerning any injury, illness or his/her physical condition and ability to participate in athletics at ______________________________ (School Name), including copies of medical records for treatment provided to me prior to or after the date signed below. PSM may disclose the information to the School, its administration, coaching and athletic staff for the purpose of informing them of my physical condition and playing status. I expressly authorize PSM to discuss my condition with these individuals.

If the Athlete is over 18: I also authorize PSM to release my medical information to my parent(s)/guardian(s) identified above.

I understand that I may revoke this authorization at any time by submitting written notice of my revocation to PSM at 11420 Parkview Circle, Fort Wayne, IN 46845. The revocation will not affect any action already taken in reliance on this authorization. If not previously revoked, this authorization will terminate one (1) year from the date below.

I understand that information disclosed pursuant to this authorization, including to the School, its administration, coaching and athletic staff may be re-disclosed and no longer protected by federal privacy laws. PSM will not be responsible for any such further use or disclosure of the information.

I understand that PSM will not condition the provision of treatment, payment, or eligibility for benefits on whether I approve the release of my medical information and sign this Authorization.

____
Printed Name of Athlete if 18 or over or Parent or Guardian (if Athlete is under 18)

____
Signature of Athlete if 18 or over or Parent or Guardian (if Athlete is under 18)

Relationship to the Athlete ______________________________

Date ____________________

You Are Entitled To A Copy Of This Authorization.
To request a copy please contact PSM at (260)266-4007.