Name of Racer _____ Birth Date _____

Address _____ **Tour of America's Dairyland** Event Name

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Wheaton Franciscan Healthcare to evaluate and furnish medical care and treatment as necessary through ATHLETIC TRAINING SERVICES for the above named athlete. Additionally, I grant the athletic trainer's permission to share protected health information as required in medical care situations with other healthcare providers involved in the care of the athlete.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, do hereby acknowledge that Wheaton Franciscan Healthcare has provided to me a copy of Wheaton Franciscan Healthcare's Notice of Privacy Practices explaining:

- How we use and disclose your health information
- Your privacy rights with regard to your protected health information
- **Our obligations to you concerning the use and disclosure of your protected health information**

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, do hereby authorize the Wheaton Franciscan Healthcare Certified Athletic Training staff to use and disclose the protected health information of the above athlete for purposes of participation in the Tour of America's Dairyland events. Protected health information will be used by those individuals participating in Tour of America's Dairyland events receiving Athletic Training Services as well as the directors and staff of Tour of America's Dairyland 2017.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Receive Copy of This Authorization - I understand that if I agree to sign this authorization, I must be provided with a copy upon request. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form. If I choose not to sign this form, it may limit my ability to participate in Athletic Training Services. **Right to Withdraw This Authorization –** I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Wheaton Franciscan Healthcare. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE

This authorization is good through 2018 for the above athlete's participation in Tour of America's Dairyland events for Wheaton Franciscan Healthcare Athletic Training Services.

I have had an opportunity to review and understand the content of this form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PARENT/LEGAL REPRESENTATIVE

_____ _____

Signature/Relationship *Date*

Original: Wheaton Franciscan Healthcare
Copy: Athlete/Parent/Legal Representative/Guardian