Ascension

Athlete/Participant Information - Please print legibly.

Last Name:	First Name:
Phone #:	Email Address:
Home Address:	
__ Female __ Male	Age:

CONSENT FOR CARE AND TREATMENT

I, the undersigned, understand I should consult with my personal healthcare provider if I have any concerns regarding participating in the Ascension Wisconsin sports medicine program, as more fully described in the Athletic Trainer Program Agreement between Ascension Wisconsin and:

School/Organization/District: **Tour of America's Dairyland**.

I further understand and do hereby agree and give my consent for Ascension Wisconsin 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 my care.

LIABILITY WAIVER

I acknowledge that my participation in this event involves a risk of injury, including bodily injury, and assume the risk for same. On my own behalf and on behalf of my heirs and legal representatives and to the fullest extent permitted by law, I hereby release, waive, absolve, discharge and agree to hold harmless Ascension Wisconsin and their respective directors, officers, employees, affiliates, members, agents and representatives, of and from any and all liability for injury, death, or damages and/or any other claims, demands, losses or damages, incurred by me in connection with any aspect of the Ascension Wisconsin sports medicine program and any medical treatment I may receive from any Ascension Wisconsin provider, while participating in the sports medicine program event.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, do hereby acknowledge that Ascension Wisconsin has provided to me a copy of its Notice of Privacy Practices explaining:

- How Ascension Wisconsin uses and discloses my health information
- My privacy rights with regard to my protected health information
- Ascension Wisconsin's obligations to me concerning the use and disclosure of my protected health information

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, do hereby authorize Ascension Wisconsin's providers and training staff to use and disclose the protected health information of the above athlete for purposes of participation in any event I participant in at the above-named School/Organization/District. Protected health information will be used by those individuals participating in this event related to my care, as well as the directors and staff of the above-named School/Organization/District.

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

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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 Ascension Wisconsin. 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.

I HAVE READ THIS CONSENT TO TREAT, RELEASE, AND WAIVER OF LIABILITY, UNDERSTAND IT, VOLUNTARILY AGREE TO IT, AND FURTHER UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT.

Signature:	Date:
Signature of Parent/Legal Guardian: (If participant is less than 18 years old)	
Relationship to Participant:	Date: