ATI Physical Therapy Consent Form

Consent to treatment:

I hereby grant consent for treatment or services to be provided by ATI Physical Therapy athletic training staff and team physicians.

Disclosure of Protected Health Information:

I understand that my personal health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (FERPA) and may not be disclosed without either my authorization or consent. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation.

I understand that my protected health information will or could be used by athletic training staff for purposes of providing athletic training and medical services, reporting and providing information, and communications with coaches, administrators, physical therapists, doctors, and other allied health professionals. This authorization will allow athletic trainers to disclose medical information to coaches, school officials, and athletic directors on a "need to know" basis. This will ensure the safety of the athlete while participating in sports, as well as establish a communication channel for coaches to stay abreast of an athlete's playing status and medical condition. Medical information shared between medical providers, coaches and school administrators is confidential information and will not be shared to those outside these positions.

I herby consent to and authorize ATI Physical Therapy's athletic trainers, physical therapists, and other health care personnel to disclose protected health information and any related information regarding an injury or illness during my training for, and participation in athletics to the individuals or entities noted above for the purposes stated. I also consent to and authorize the release of protected health information to my parents or guardians.

I also understand that the local, regional and national media are not covered by HIPAA or FERPA and that these legal requirements will not apply.

Expiration or Revocation:

This authorization/consent expires one year from the end of participation in athletics. I understand I have the right to revoke authorization at any time by sending written notification to ATI Physical Therapy's Director of Sports Medicine.

Both the Athlete and Parent/Guardian Must Sign if under 18 years of age.

Name of Athlete_____

Signature of Athlete_____Date_____

Name of Parent/Guardian_____

Signature of Parent/Guardian_____Date_____