

Midway College MEDICAL CONSENT FORM

PLEASE READ THE FOLLOWING CONSENTS CAREFULLY
If you (student) are under 18 years of age, your parents must also sign

PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge receipt of, have read, and do understand Midway College's Notice of Privacy Practices. I understand that this is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I also understand that this notice describes how my protected health information may be used and disclosed, and how I can get access to my individually identifiable health information.

MEDICAL CONSENT

I hereby grant permission to the Midway College team or other treating physicians designated by Midway College, to provide me with any medical or surgical care they deem necessary to my health and well-being as a result of injuries or other medical conditions occurring as the result of or during Midway College athletic activities.

I further authorize the athletic trainers at Midway College who are under the direction and guidance of the Midway College team or other physicians to provide me with any preventative, first aid, treatment, rehabilitative, or emergency care/treatment they deem reasonably necessary to my health and well-being as a result of injuries or other medical conditions occurring as the result of or during Midway College athletic activities.

If reasonably necessary to provide the care described in the preceding two paragraphs, I grant permission to Midway College officials to allow for hospitalization on my behalf at an accredited hospital.

AUTHORIZATION FOR RELEASE OF MEDICAL / TREATMENT INFORMATION

- A. I hereby authorize Midway College athletic trainers, administration, team physicians, and coaches to release medical information to insurance carriers regarding any information concerning illness or injury relative to my past, present, or future participation in athletics at Midway College.
- B. I hereby authorize any medical facility, physician, or medical personnel who has attended me to disclose, when requested by Midway College, any and all information regarding my illness, or injury, medical history, consultation, diagnostic tests, recommendation and copies of all hospital and medical records. A photo copy of this authorization shall be considered valid and effective as the original.
- C. If I, the student, choose to authorize any individuals or organizations other than those listed above access to any of my protected health information, I agree to provide the Head AT with written authorization providing specific or general disclosure of my protected health information by completing a Patient Information Disclosure Form obtained from the Head AT.

I hereby grant permission on behalf of my minor daughter or ward

ATHLETE'S SIGNATURE

DATE

PARENT OR GUARDIAN SIGNATURE
(If required)

DATE