UPMC LIFE CHANGING MEDICINE

UPMC Sports Medicine
Athletic Training and Development

3200 South Water Street
Pittsburgh, PA 15203
T 412-432-3770
F 412-432-3774

Dear Parent/Guardian:

As part of a contractual agreement between UPMC Sports Medicine and *East Allegheny School District,* UPMC provides *(1) full-time and (1) part-time* certified athletic trainer to aide in the prevention, recognition, evaluation, and treatment of athletic injuries.

To treat your son or daughter, two forms must be signed by parents/guardians of student-athletes. One is the "Consent for Treatment, Payment and Health Care Operations." This gives the athletic trainer(s) and other associated healthcare personnel permission to assist or participate in providing care in the event of an injury or illness. The other form is the "Authorization for Release of Protected Health Information." This form allows the athletic trainer(s) to communicate with medical personnel and the school district's athletic department personnel in order to provide consultation, treatment, and establish a plan of care for the injured or ill patient.

Please note that these forms have no relationship to your health insurance plan and in no way influence your choice of medical care. UPMC, as the employers of the athletic trainer(s) at *East Allegheny School District,* must have these forms completed in order to provide care for your son or daughter to comply with privacy and standard consent to treat laws.

In addition, copies of the UPMC Notice of Privacy Practices document are available at the school, can be sent in the mail upon request, or viewed at http://www.upmc.com/HospitalsFacilities/hipaa/Pages/privacy-notice.aspx.

Please sign the attached documents. If you revoke this authorization or consent form, please contact the athletic office at *(412) 824-9700 ext. 1005.* We look forward to your student-athlete's safe participation in *East Allegheny School District* athletics. Thank you for your time.

Sincerely,

Leigh Keller, BS, ATC, LAT
Certified Athletic Trainer
UPMC Center for Sports Medicine

UPMC
Sports Medicine

UPMC/UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC)
CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I _____(print or type name) consent to the provision of care. I understand that this care may include medical–treatment, special tests, exams, evaluation, treatment, and rehabilitation of athletic injuries. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

I understand and agree that others may assist or participate in providing care. This may include, but may not be limited to team physician, school nurse, and licensed physical therapists. Under the direction of a certified athletic trainer. college/uni versity athletic training students and high school student aides may also provide care.

I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

I understand that copies of the UPMC Notice of Privacy Practices document are available at the school, can be sent in the mail upon my request or viewed at http://www.upmc.com/HospitalsFacilities/hi paa!Pages lprivacy-notice.aspx. I give UPMC and its designees permission to use my information as described in the UPMC Notice of Privacy Practices. _____Patient Initials

_____ _____
Patient stgnature Date

_____ _____
Signature/identify on behalf of patient/relationship Date

_____ _____
Signature/identify on behalf of patient/relationship Date

For Office Use Only:

Sign here if patient failed to acknowledge receipt of Notice of Privacy Practices: _____

Reason given by patient for failure to acknowledge receipt of the Notice of Privacy Practices:

_____

UPMC
Sports Medicine

UPMC/UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC)
Authorization for Release of Protected Health Information

RELEASE OF PROTECTED HEALTH INFORMATION

- I authorize UPMC to provide information related to my care to family/school/team physicians, school nurses, coaches, athletic directors, school principals, EMS personnel, and such other persons as is necessary needed for them to provide consultation, treatment, establish a plan of care or determine whether the Athlete may resume participation in school or sports activities.
- I authorize UPMC to use my billing information for UPMC internal departmental reporting purposes.
- I authorize UPMC (including its hospitals, other entities and programs) to use medical or other information maintained on electronic information systems or stored in various forms in connection with my care, health care operations, or payment for treatment and services.
- I understand that the health record(s) released by UPMC may be re-disclosed by the facility/person that receives the record(s) and therefore (I) UPMC and its staff/employees has no responsibility or liability as a result ofthe re-disclosure and (2) such information may no longer be protected by federal or state privacy laws.
- I understand that this Authorization is in effect for a period of one year from the date signed by the Athlete.
- I understand that this Authorization is in effect if I am treated for an injury during off-season workouts; however, no time frame specified shall go beyond one year from the date of signature.
- I understand that I have the right to revoke this Authorization form at any time by sending a written request to UPMC at the location where the Authorization was provided.
- I understand that my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.
- I understand that I am entitled to a copy of this completed Authorization form.

AGREED

Athlete/Patient Signature _____ Date _____

Parent/Guardian Signature (If Athlete is a Minor) _____ Date _____ Relationship _____

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Dear Parent/Guardian:

East Allegheny School District, in conjuction with UPMC Sports Medicine, is providing ImPACT baseline neurocognitive tests to designated student-athletes participating in certain interscholastic sports as agreed by the School District and UPMC in their Athletic Training Services Agreement. Designated student-athletes from *East Allegheny School District* will participate in ImPACT baseline neurocognitive testing to assess key functions affected by a concussion.

The ImPACT baseline neurocognitive test is used to establish a benchmark score when an athlete is in his or her non-concussed or "normal" state. The result of the ImPACT baseline neurocognitive test is used as a comparison tool to determine if your son or daughter can safely return to play following a subsequently incurred concussion.

A concussion potentially can affect the student-athlete's school learning and social activities. Coordinated treatment between the UPMC certified athletic trainer, medical personnel, and the school district is important to assist in the student-athlete's recovery.

If for any reason, you think your son or daughter may have had a hit to the head or any other potential for a concussion prior to taking the ImPACT baseline neurocognitive screening test, it is strongly recommended that he or she promptly seek medical care from UPMC Sports Medicine concussion experts or other health care professionals qualified in concussion diagnosis and treatment.

It should be noted that this ImPACT baseline neurocognitive test does not evaluate the subject for a concussion; identify past concussion(s); prevent future concussions or determine if your son or daughter is predisposed to a concussion.

Additional information regarding the UPMC Sports Medicine Concussion Program is available on the UPMC Sports Medicine website at: www.upmcsportsmedicine.com.

Please sign below acknowledging that you have read this form and consent to your son/daughter taking the ImPACT baseline neurocognitive test.

Parent/Guardian Signature _____ Date _____

Certified Athletic Trainer Signature _____ Date _____