

## **Consent for Purposes of Treatment, Payment and Healthcare Operations**

I, \_\_\_\_\_, consent to the use or disclosure of my protected health information by the Sports Medicine staff for the purpose of:

- Evaluating an injury/illness or providing treatment to me,
- Coordinating with my coaches to establish appropriate levels and limitations of my physical abilities with an athletic activity
- Obtaining payment for my health care bills, or
- To conduct health care operations of CNU Sports Medicine
- As a means of communication between Christopher Newport University Athletic Trainers, consulting physicians, my coaches, and my parent(s).

I understand that evaluation or treatment of me by the Sports Medicine Staff and my participation in athletics at Christopher Newport University may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I may revoke this consent in writing at any time except to the extent that the Sports Medicine staff has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that this form is valid for one calendar year from the date of my signature below.

I understand that I have the right to request restrictions as to how my health information may be used. I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept this consent.

Athlete signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent signature if under age 18: \_\_\_\_\_

Date: \_\_\_\_\_