

NOTICE OF PRIVACY PRACTICES

Effective Date: November 17, 2003

LAKE WASHINGTON HIGH SCHOOL ATHLETIC MEDICINE

As defined by the Health Insurance Portability and Accountability Act (HIPAA), the Lake Washington High School Athletic Training Room is not considered a covered entity. However, in accordance with the confidentiality of medical records practices as designated by HIPAA, the Lake Washington High School Athletic Medicine Staff will not release information to any of the below mentioned parties unless specifically designated.

I give permission to release medical information when necessary as it relates to participation in my sport to the below designated persons:

- a) Coach of the sport in which I participate
- b) Athletic Medicine Staff including Certified Athletic Trainers, Student Athletic Trainers, physicians and physical therapists from whom I receive medical care for an injury/illness related to my participation in LWHS athletics.
- c) Lake Washington High School Administration
- d) My parents/ legal guardians

I understand that I may specifically request, in writing, that certain medical information not be released to the above noted persons on an incident specific basis.

I understand that the LWHS Athletic Medicine Staff will not release any information related to my medical condition to any other persons, except those previously designated, including members of the media unless permission is obtained from me on an incident specific basis. This authorization/consent expires at the end of my sports season including any post-season play.

Athlete's Printed Name

Sport

Athlete's Signature

Date

Parent or Legal Guardian Signature (if under 18)

Date

Athletic Medicine Staff Signature

Date

OVER.

**LAKE WASHINGTON HIGH SCHOOL ATHLETIC MEDICINE
CONSENT TO EVALUATE/TREAT**

STUDENT NAME: _____ **SPORT:** _____

As a parent or legal guardian, I authorize a Certified Athletic Trainer to examine the above-named student and in the event of an injury to administer emergency care and to arrange any consultation by a physician or specialist, including a surgeon as deemed necessary to ensure proper care of any injury. Every effort will be made to contact parent or guardian to explain the nature of the problem prior to any involved treatment.

Parent/Legal Guardian's Printed Name

Date

Parent/Legal Guardian's Signature

OVER