PARKVIEW SPORTS MEDICINE

STUDENT-ATHLETE

PARENT OR GUARDIAN

STREET ADDRESS

STREET ADDRESS

CITY, STATE, ZIP

CITY, STATE, ZIP

PHONE EMAIL

PHONE EMAIL

By signing below, I understand and agree to the following terms and conditions:

Consent to Treat and Receive Athletic Training Services:

I consent to Parkview Sports Medicine (''PSM'') and its athletic trainers, physicians, and other qualified providers providing first aid, medical treatment, and athletic training (collectively, the ''Services'') in connection with my participation in 's (''School'') athletic program(s). I understand that in the event of injury or illness, PSM will make reasonable efforts to contact a parent/guardian at this number: if additional evaluation or information is needed. If a parent/guardian cannot be reached, PSM will provide appropriate medical treatment believed to be in the best interest of the student-athlete. I understand that PSM does not obtain prior insurance pre-certification or authorization and that I will be responsible for obtaining such authorization or pre-certification, if necessary.

Right to Use Name, Image, and Likeness:

I authorize PSM to interview, photograph and videotape me while participating in athletic events, practices, and other functions associated with the School. I grant PSM and its affiliates the perpetual right to use my name, image, likeness, biographical information, and other identifying information (collectively, ''Likeness'') in connection with PSM's products and services and the marketing thereof and any derivative works PSM may create from any of the foregoing. PSM may display my Likeness, any interviews I provide, and any information provided in any interview I provide on its website and social media and any advertisements or other publications of PSM.

Acknowledgement of Receipt or Declination of Notice of Privacy:

I acknowledge PSM has offered me a copy of its Notice of Privacy Practices (''Notice''). The Notice describes how PSM may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information, and rights that I have regarding my health information. I understand that I should read it carefully. My signature, below, indicates that I have either been offered or have received a copy of the

Notice. The Notice is also available at the front desk at all PSM offices and at www.parkviewsportsmedicine.com. PSM reserves the right to change the Notice at any time. I understand that I can obtain any revisions to the Notice by accessing the PSM or requesting a copy be mailed to me.

Assumption of Risk, Release of Claims, and Limitation of Liability:

I understand, accept, and assume all risks (including risks of injury or even death) associated with participating in the School's athletic program(s), including the risks of receiving the Services. I confirm I have consulted with a physician regarding said risks and such physician has given his/her approval of my participation. Accordingly, on behalf of myself and my heirs, I forever release PSM and its affiliates, directors, officers, employees, and agents from, and waive, any and all claims, causes of actions, liabilities, damages, costs, and expenses relating to PSM's provision of the Services except to the extent of PSM's gross negligence, willful misconduct, or violation of law.

Marketing Materials:

I hereby consent to receive marketing communications from PSM regarding its services.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS IN THEIR ENTIRETY. I UNDERSTAND THAT BY MAKING AND SIGNING THIS AGREEMENT, I SURRENDER LEGAL RIGHTS INCLUDING MY RIGHT TO SUE AND I DO SO FREELY AND VOLUNTARILY.

_____

STUDENT-ATHLETE SIGNATURE

_____

PARENT OR GUARDIAN SIGNATURE (IF ATHLETE IS UNDER 18)

_____

DATE

A photocopy of this authorization shall be considered as valid as the original.

PARKVIEW SPORTS MEDICINE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

STUDENT-ATHLETE

STREET ADDRESS

CITY, STATE, ZIP

PHONE **EMAIL**

PARENT OR GUARDIAN

STREET ADDRESS

CITY, STATE, ZIP

PHONE **EMAIL**

I hereby authorize Parkview Health System d/b/a Parkview Sports Medicine and its athletic trainers, physicians and providers ("PSM") to release any and all information, including my protected health information, regarding medical treatment provided to me concerning any injury, illness, and my physical condition and ability to participate in athletics at: (the "School"), including copies of medical records for treatment provided to me prior to or after the date signed below. PSM may disclose the information to the School, its administration, coaching and athletic staff for the purpose of informing them of my physical condition and playing status. I expressly authorize PSM to discuss my condition with the School and these individuals.

If the Student-Athlete is 18 years or older: I also authorize PSM to release my medical information to my parent(s)/guardian(s) identified above.

I understand that I may revoke this authorization at any time by submitting written notice of my revocation to PSM at 11420 Parkview Circle, Fort Wayne, IN 46845. The revocation will not affect any action already taken in reliance on this authorization. If not previously revoked, this authorization will terminate one (1) year from the date below.

I understand that information disclosed pursuant to this authorization, including to the School, its administration, coaching and athletic staff may be re-disclosed and no longer protected by federal privacy laws. PSM will not be responsible for any such further use or disclosure of the information.

I understand that PSM will not condition the provision of treatment, payment, or eligibility for benefits on whether I approve the release of my medical information and sign this authorization.

STUDENT-ATHLETE SIGNATURE

PARENT OR GUARDIAN SIGNATURE (IF ATHLETE IS UNDER 18)

DATE You Are Entitled To A Copy Of This Authorization. To request a copy please contact PSM at (260)266-4007.