Carolinas HealthCare System is

Atrium Health

Student Athlete Request For Treatment
Release Of Medical Information
Photo And Video Release

Name of Student Athlete: _____

Request For Treatment

My/child's school has engaged Atrium Health ("AH") to support and provide healthcare services for students, athletic staff, and others. I give permission for AH providers/athletic trainers/registered dietitians ("AH Sports Medicine Team") to provide me/my child with care deemed appropriate by the AH Sports Medicine Team. I understand that I have the right for an explanation to the nature and purpose of any proposed procedure and other options for treatment. I understand an explanation of the risks associated with each of them in accordance with the recognized standards of medical and healthcare practice will be provided. If my child is under 18, I confirm that my child can request and receive care on their own from the AH Sports Medicine Team and I consent to the AH Sports Medicine Team providing that care. I agree the AH Sports Medicine Team may refer me/my child to an outside provider and that I/my child may engage in a separate provider-patient relationship. I/my child consent to receive services by telemedicine (using interactive audio, video, or data communications to carry out healthcare benefiting a patient) if appropriate for my/child's condition, and I understand the risks, benefits and alternatives of doing so. This Request for Treatment is valid for two years from the date signed below.

Release Of Medical Information

I give permission for Atrium Health ("AH") to share my/my child's medical information related to or arising from the AH Sports Medicine Team (including clinical, lab and radiology reports) with other AH providers, independent providers, the school system, or other school sports program representatives (such as coaches and school-employed athletic trainers). I understand and agree that the AH Sports Medicine Team may use and share my/child's information to coordinate care outside of the school's athletic program. I understand that AH is providing the services under an agreement with the school system and I agree that it may share my/my child's information with the school system or store information on school system platforms. This Release of Medical Information will be valid for two years from the date signed below.

I have read and agree to the above Request for Treatment and Release of Medical Information.

_____	_____	_____
Printed Name of Student over 18 or Parent/Guardian	Student over 18 or Parent/Guardian Signature	Date

Photo/Video Consent And Release And Communication Authorization

I give Atrium Health ("AH") the unlimited right to use and/or reproduce photographs, video, likenesses or the voice of me/my child in any legal manner and for the internal or external promotional and information activities of AH, including on closed or public websites/intranet web pages/social media sites used by AH or the school. This permission includes allowing the AH Sports Medicine Team and AH to post pictures of me/my child at a sporting events, at school, or in the athletic training rooms. I also agree that the AH Sports Medicine Team may use unsecured methods to communicate with me/my child, such as through unencrypted email or social media platforms or engines. I understand the risks of using these communications and agree that AH may use them to communicate with me/my child, such as to make appointments to see the AH Sports Medicine Team or to follow up on care. I also agree, for myself and my child, to give up any present or future compensation rights to use of the above stated materials. This Photo/Video Consent and Release and Communication Authorization will be valid until AH does not need the information and images any longer.

I have read and agree to the above Photo/Video Consent and Release and Communication Authorization.

_____	_____	_____
Printed Name of Student over 18 or Parent/Guardian	Student over 18 or Parent/Guardian Signature	Date