EXHIBIT A
to
Athletic Trainer Services Agreement

[This document may be included with a School District consent to participate in athletics document]

CONSENT FOR TREATMENT

I hereby authorize certified athletic trainers acting on behalf of Faith Regional Health Services to evaluate and treat any injury that occurs as a result of my participation in athletics at the School District. This includes all reasonable and necessary preventive care, treatment and rehabilitation for these injuries.

______________________________	______________________________
Printed Parent/Guardian Name	Date

____
Signature of Parent/Guardian

Notice of Privacy Practices

I hereby acknowledge receipt of the Faith Regional Health Services Notice of Privacy Practices.

______________________________	______________________________
Printed Parent/Guardian Name	Date

____
Signature of Parent/Guardian

EXHIBIT B
to
Athletic Trainer Services Agreement

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name: ______________________________

D.O.B.: ________________ **Address:** ____________________

Phone: ________________

I hereby authorize Faith Regional Health Services (the "Hospital") to disclose to School District's athletic coaches and/or other School District officials my protected health information created or obtained by the Hospital in the course of conducting an injury clinic and athletic training services. This disclosure is made at my request.

The Hospital may disclose any and all information which it has created or obtained regarding my care at such injury clinic or through the athletic training services.

I understand and acknowledge that:

1. I can revoke this Authorization at any time by giving my written revocation to the Hospital at the following address: Faith Regional Health Services, 2700 W Norfolk Avenue, Nebraska 68701. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this Authorization.

2. The Hospital may NOT condition treatment, enrollment, or eligibility for benefits on whether I sign this Authorization.

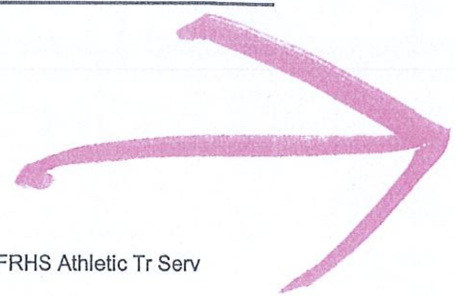
3. I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law.

4. This Authorization is effective for 12 months after the date it was signed.

A photocopy or exact reproduction of this signed Authorization shall have the same force and effect as the original.

______________________________ ______________________
Printed Parent/Guardian Name Date

____
Signature of Parent/Guardian



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