Spartanburg Regional Health Services District, Inc.
General Consent to Treat and Release

Consent for Medical Treatment. I, the student/athlete named below (if over the age of 18) (the "Student"), or parent/legal guardian of the Student, hereby authorize and grant permission to Spartanburg Regional Health Services District, Inc. (the "District"), including without limitation its employed sports medicine personnel and certified athletic trainers, (the "District Employees"), to provide to the Student any treatment or medical care that the deem reasonably necessary to the health and well being of the Student, including without limitation medical, surgical and diagnostic procedures. I also hereby authorize the District Employees to render to the Student any preventive, first aid, rehabilitative or emergency treatment that they deem reasonable necessary to the health and well-being of the Student. I am aware that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made as to the result of treatments or examinations. **I understand and acknowledge that the Student is not being compelled to utilize the services of the District Employees, and that the Student is free to seek medical care and treatment from any provider of his or her choosing.**

Consent for Release of Information. I hereby authorize the District, its officers, employees, and agents to release information regarding Student's protected health information and any related information regarding any injury or illness during Student's training for and participation in school athletics. This protected health information may concern Student's medical status or condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information (the "PHI"). This PHI may be released to other health care providers and laboratories, athletic coaches and/or school administrators, medical insurance coordinators and insurance carriers, as well as any federal or state regulatory agencies as required by law. I hereby fully discharge all parties to whom this authorization extends from any and all privilege in connection with the disclosure of information included at any time by notifying in writing the District Regional Sports Medicine Manager, but if I do, it will not have any effect on actions that the District took in reliance of this authorization/consent prior to receiving the revocation. This authorization/consent expires one 91) year from the date it is signed.

Acknowledgement of Receipt of Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices, describing how my PHI may be used or disclosed. I understand that I should read it carefully, and that it may be accessed at www.srhs.com.

Waiver of Claims. In consideration for the care and treatment provided by the District Employees, I hereby release and hold harmless the District, its officers and agents from and against any claim, cause of action or other expense arising out of the services provided by the District Employees, except to the extent that such claims arise out of the District's gross negligence or intentionally injurious acts.

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Printed Name of Parent/Guardian or Legally Authorized Representative | Relationship to Student

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Signature of Parent/Guardian (if student is under 18 years of age)

_____ _____

Name of Student | Signature of Student (if over 18 years of age)

_____

Date