CONSENT AND RELEASE OF LIABILITY &

AUTHORIZATION TO RELEASE ASSESSMENT RECORDS

Student seeks to participate in one or more physical assessments at a Summit location. Such assessments are designed to measure potential physical instabilities or vulnerabilities. Assessments may involve running, throwing, or jumping. These physical assessments do not constitute the provision of health care at Summit Orthopedics, and Student will not become a Summit Orthopedics patient as a result of participating in the physical assessment. Student/parent will not be charged for the physical assessments.

STUDENT/PATIENT NAME: DOB: ADDRESS: PHONE NUMBER:

Consent and Release of Liability

Student (I) or Student’s parent or legal guardian consents to Summit providing physical assessments to Student, and agrees as follows:

I understand my/my Student’s participation in physical assessments (the “Activity”) involves the inherent risk of injury and I expressly assume these risks.

I represent that I am/my Student is capable of participating in the Activity safely. Understanding the risks inherent in the Activity, I request that I/my Student be granted permission to participate in the Activity.

I release, waive, forever discharge, and promise not to sue Summit Orthopedics and its employees, from and against all liability for any harm, injury, damage, claims, demands, actions, causes of action, costs, and expenses of any nature which I and/or my Student may have arising out of or related to the Activity.

This Waiver and Release shall bind the members of my family/my Student’s family, estate, heirs, administrators, personal representatives, or assigns.

Consent to Use of Assessment Records

With respect to records created as a result of the Activity, I direct Summit Orthopedics to disclose and release such records (1) to me and (2) to my/my Student’s school, coach, athletic department listed below. I further authorize Summit Orthopedics to maintain a copy of the records confidentially for use to treat me/my Student in the event I/my Student become(s) a patient of Summit Orthopedics in the future.

School That Can Receive Records: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coach or Athletic Department That Can Receive Records: Any Coach or Athletic Department of the School with whom Student interacts.

*Authorization Timeframe [school year]:*

 By checking this space, I allow the ongoing exchange of information related to the assessment records between Summit and the above parties until this authorization expires or is revoked.

*I understand the following:*

» This authorization may be revoked in writing at any time by notifying Summit Orthopedics; however, if Summit Orthopedics has already released assessment records based on my consent, my request to stop will not apply to previously disclosed health information.

» The information disclosed to the School or coach, for example, pursuant to the authorization, has the potential to be redisclosed. I understand and accept such risk.

I am making this release/authorization/consent voluntarily.

Printed Name

Signature Date Signed

If not signed by the Student, authorized person’s authority to sign:

Parent of child under age 18 Guardian (include court order) Authorized Representative