



## WINNING MEDICINE INTERNATIONAL

### **NOTICE OF PRIVACY PRACTICES: PROTECTIVE HEALTH INFORMATION (PHI)**

High quality health care is built on trust. That means we must respect your privacy and the confidentiality of your medical information. We've made sure that your medical information can be read or accessed only for purposes related to medical care. Policies regarding access to your medical records by our staff and employees carefully outline the circumstances under which your medical information may be released to parties outside the hospital or your physicians practice.

The general rule regarding release of patient's medical record is that information contained in a patients medical record may be released to third parties only if the patient has consented to such disclosure. The patient's express authorization is required before the medical records can be released to the following parties: patient's attorney or insurance company; patients employer, unless a worker's compensation claim is involved; member of the patients family, except where the family member has been appointed the patient's attorney under a durable power of attorney for health care; government agencies; and other third parties.

In order for the Event to provide WMI Corporation with data to be stored in its confidential Electronic Medical Record system related to medical health history and medical care given during the 2011-2012 Year, I authorize Winning Medicine International (WMI Corporation) to store any and all information contained in the treatment and health history form(s) that WMI Corporation medical personnel will complete in conjunction with my medical care received. I acknowledge that my treatment at the Event will not be affected by my decision to sign or not sign this authorization.

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*Signature of Patient/Legal Guardian*

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*Patient Name (printed)*

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*Relationship if not Patient*

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*Witnesses if unable to sign*



I consent     I do not consent to medical treatment for injuries/illnesses by Winning Medicine International Medical Staff Personnel and / or Hospital Medical Staff. I authorize treatment by such personnel in the event of injury or illness. I also give permission to release these records to WMI, Inc.

I certify that I am over the age of 18

I certify that I am the Parent/Legal Guardian of the patient below (who is under the age of 18).

\_\_\_\_\_  
(Athlete's Signature or Parent / Legal Guardian Signature)

\_\_\_\_\_  
(Date)

|                 |               |
|-----------------|---------------|
| Location/Event: | Today's Date: |
|-----------------|---------------|

**Patient Identification:**    **Athlete**    **Staff**                       **Other:**

|         |   |                                |
|---------|---|--------------------------------|
| Name    | Sex: <input type="checkbox"/> M <input type="checkbox"/><br>F | DOB: ___/___/___<br>Age: _____ |
| Address | Home Tel: (       )   | Cell Tel: (       )            |
| City    | State   | Zip                            |