Sports Medicine and Performance Center

IN PARTNERSHIP WITH BOULDER COMMUNITY HEALTH

PATIENT CONSENT TO USE PHOTOGRAPH/VIDEOTAPE, FILM/INTERVIEW, AND/OR AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth: _____

Authorized to Use/Disclose Information: Boulder Center for Sports Medicine

Authorized to Receive Information: _____

Purpose of Use/Disclosure:

- X Publication in newspaper(s), magazine(s), or other publication
- x Broadcast by radio or television
- X BCH Marketing and Public Relations materials/publications
- X Educational uses such as lecture or class

Description of Protected Health Information to be used/disclosed:

I understand that Boulder Community Hospital is acting only as the intermediary, making it possible for the aforementioned recipient to contact me if necessary.

As such, I hereby agree to hold Boulder Community Hospital free of any and all liability that could potentially come from release of information outlined above. I understand that the release of the above information is being carried out with my permission and I assume full responsibility.

I understand that:

1) I am signing this consent voluntarily.
2) If I do not sign this consent, my health care will not be affected.
3) I may revoke this authorization at any time in writing, but if I do, it will not have any affect on actions taken prior to the date of my written notice. Written revocation should be sent in writing to the hospital's Public Relations Department, Mapleton Center, 311 Mapleton Ave., Boulder, CO 80301.
4) If the recipient of this information is not a health care provider or health plan, the information released is no longer protected by federal privacy regulations.
5) I should retain a copy of this authorization after I sign it.

I have read the above and I authorize the release of the requested information described above.

Signature: _____ Date: _____

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When you understand and consent to each of the points listed below please sign at the bottom.

Explanation of the Exercise Stress Test

You will perform an exercise based test using either a treadmill or a stationary bicycle. Exercise will begin at a level that you can easily accomplish and get harder during a series of stages. Depending on our goals you may be asked to give a maximal, as hard as you can, effort. The testing staff will stop the procedure in the event of adverse symptoms. These may include, but are not limited to; Changes in Heart Rate, Blood Lactate, Heart Rhythm, Blood Pressure or General Observation. This test is voluntary and can be stopped by you at any point in time.

Risks and Discomfort

There is risk involved with exercise; statistics show a mortality rate of .5 per 10,000 exercise tests and heart attack rate of 3.6 per 10,000 tests. Exercise can induce changes including abnormal blood pressures, dizziness, abnormal heart rhythms, heart attack, stroke, or death. Every effort will be made to minimize these risks by evaluation of medical history and observations during the test. Emergency equipment and trained personnel are available if needed.

If your test involves an EKG, please understand that it is not infallible. Even if the interpretation of your EKG indicates good heart health, there is no guarantee that you will not undergo an adverse cardiac event at any time in the future.

Exercise, by nature, tends to carry a level of discomfort. Depending on the type of testing you under-go, various pieces of equipment (example: mouth-pieces for breath collection) may be utilized; There may be some discomfort, claustrophobia or other feelings directly associated with the use of this equipment. If your particular test involves a lactate profile, we will perform a finger-stick blood draw during each exercise stage. This procedure is similar to that of a person with diabetes who monitors their blood sugar.

Responsibilities of the Participant

Information you possess about your health status or previous experience of unusual feelings with physical effort may affect the safety and value of your exercise test. It is very important that you accurately and fully report your medical history, medications and current state. During the test, your prompt report of symptoms including: Chest Pain, Difficulty Breathing, Dizziness and / or Fatigue are also of great importance. You are responsible for fully disclosing such information when requested by the testing staff.

Expected Benefits

If Pulmonary Function/ Metabolics are tested the information will be useful to better understand your body breathes and utilizes oxygen and carbon dioxide.
If EKG is recorded it will assist a physician in evaluating your cardiovascular system during exercise, which may be different from the results of a resting EKG.
If Blood Lactate is tested; an understanding of your energy production systems will help guide exercise recommendations.

Inquiries

Any questions regarding procedures used in the exercise test or the results of your test are encouraged. If you have any concerns or questions, please ask us for further explanations

Consent

Performance of this exercise stress test is voluntary. You are free to stop the test at any point.

I have read the foregoing and I understand the test procedures that I will perform and the associated risks and discomforts. Knowing these risks and discomforts, and having had an opportunity to ask questions that have been answered to my satisfaction, I consent to participate in the above tests.

_____ _____

Date Signature of Participant or Legal Guardian

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Boulder Community Hospital Physicians' Clinics

Beacon Clinic
Boulder Center for Sports Medicine
Buffalo Ridge Medical Associates
CMA - Lafayette
Family Medical Associates
Frontier Internal Medicine
Gunbarrel Medical Center
Holistic Family Practice
Internal Medicine Associates
– Balfour, Boulder, Foothills, Lafayette
Northwest Family Medicine
Table Mesa Family Medicine

Parental Consent for Treatment

Minor Presenting Alone

I, _____ (parent/guardian), give permission to Boulder Community Physicians' Clinics to treat my child, _____ _____(child's name), DOB _____, in the event he/she presents to the clinic alone. I understand that any charges resulting from the visit will be my responsibility. The clinic has my permission to forward pertinent medical and other information from these visits to the insurance plan covering my child if applicable.

Please check one:

_____ This form is valid for one year from date of signature.

_____ This form is valid for the following dates: _____ to _____.

Parent/guardian Signature _____ **Date:** _____

Parent/Guardian Name (please print) _____

Last Updated 06/2012

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Buffalo Ridge Medical Associates
CMA - Lafayette
Family Medical Associates
Frontier Internal Medicine
Gunbarrel Medical Center
Holistic Family Practice
Internal Medicine Associates – Balfour, Boulder, Foothills, Lafayette
Northwest Family Medicine
Table Mesa Family Medicine

Parental Consent For Treatment

Minor Presenting w/Authorized Non-Parent/Guardian

I, _____ (parent/guardian), give permission for

_____(authorized non parent) to make decisions regarding the care and treatment of _____(child's name), DOB _____ and to authorize any treatment or procedures deemed medically necessary during my child's visit. I understand that any charges resulting from the visit will be my responsibility. The clinic has my permission to forward pertinent medical and other information from these visits to the insurance plan covering my child, if applicable.

Please check one:

_____ This form is valid for one year from date of signature.

_____ This form is valid for the following dates: _____ to _____.

Names of additional people authorized to make decisions regarding the treatment of my child during routine office visits:

_____ Relationship

_____ Relationship

_____ Relationship

Parent/Guardian Signature _____ **Date:** _____

Parent/Guardian Name (please print) _____

Last Updated 06/2012