AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
Schoolname High School

Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I authorize health care providers of **ATHLETE NAME**:_____, **DATE OF BIRTH**: _____, to disclose medical information regarding the injury and treatment of named individual to the following representatives of Schoolname High School: Athletic Director, Athletic Trainer, Team Physician, and Team Coach for the purposes of treatment, emergency care and injury record-keeping.

Medical Information, in this context, pertains only to patient health care records regarding a specific injury and the treatment thereof. The request for medical information includes all patient health care records regarding the care, evaluation, referral or treatment including, but not limited to, any and all records, reports, correspondence, radiographic films pertaining to the care and treatment of an injury sustained by the above-named student-athlete on _____. **(SCHOOL WILL INSERT DATE OF INJURY.)** This includes all portions of my medical records which my physicians, or other health care providers, or I have specifically designated as "confidential."

I understand that my signed authorization will be kept in a locked cabinet along with all medical information received and that said information will be available only to the individuals named above.

Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining patient's authorization.

The purpose of disclosure of medical records is to facilitate treatment of injured student-athletes. I understand that the information obtained by the use of this authorization may be subject to re-disclosure and the information obtained is therefore no longer protected by HIPAA.

This consent is revocable by the patient at any time except to the extent that the provider listed above has taken action upon it. A revocation is effective by the Health Care Provider listed above upon receipt of a written request to revoke, and a copy of the executed authorization form. A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain in effect for one year from date of signing.

This authorization specifically authorizes the health care provider named above to disclose records created at any time after the signing, regarding the specific injury, until the authorization expires one year from the date of signing.

_____ _____ _____
Athlete's (Patient) Signature Date Signed Witness Signature (Optional)

_____ _____
Parent/Guardian's Signature Date Signed