BAPTIST HEALTH®

Student-Athlete Authorization For
Disclosure of Protected Health Information

I, _____, the parent or guardian of _____ (the "student athlete"), hereby authorize the certified athletic trainers and/or sports medicine staff representing Baptist Health Floyd to gather and release information regarding the student-athlete's protected health information and related information regarding any injury or illness during the student-athlete's preparation for and participation in athletics at Clarksville High School (the "School").
This protected health information may concern the student-athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related individually identifiable health information. This protected health information may be released to other healthcare providers, hospitals and/or medical clinics and laboratories, athletic trainers, athletic coaches, medical insurance coordinators athletic and/or school administrators and officials of the Indiana High School Athletic Association. It should also be understood that student athlete medical information can be disseminated between the school nurse, athletic trainer, coaches and school administrators. School administrators have the ability to verify all medical information and communication given to the School for the safety of the athletes.

I understand that as a parent/legal guardian my authorization/consent to the disclosure of the student-athlete's protected health information may be a condition for the student-athlete's participation in interscholastic sports at the School. I understand that the student-athlete's protected health information is protected under Federal law. I, the parent/legal guardian, understand that once information is disclosed per this authorization, the information is subject to re-disclosure by the recipient and may no longer be protected under federal law. I may revoke this authorization at any time by notifying the schools athletic director in writing, but if I do, it will not have any effect on actions taken in reliance of my prior authorization. This authorization expires one year and ninety days from the date it is signed.

REQUIRES SIGNATURE FOR AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____
Print Student-Athlete Name

_____ _____
Signature of Parent / Legal Guardian Date Signed