ATHLETIC PROGRAM

In accordance with the Health Insurance Portability and Accountability Act of 1996 we are required to provide the patient or the patient's parent or legally authorized representative with the Notice of Privacy Practices describing how we use and disclose patient health information.

If you have not received a copy of the Notice of Privacy Practices, they will be available through the Athletic Trainer at your High School. We will ask you to acknowledge you have received a copy of our Notice.

We will need the authorization signed in order for us to use or disclose athletic screening health information with the coaching staff.

**HIPAA Compliant Authorization to Release Medical Information**

(The execution of this form covers only the release of information described below)

I authorize the release of the information described below to the Athletic Director or personnel involved in the care of the athlete.

Information Requested: ___ Results of athletic health screening/injury reports

Purpose: ____At the request of the individual being screened/injured

Authorization: I certify that this request has been made voluntarily, and this authorization will expire on May 30, 2012. Please note that the services of the Athletic Trainers will be provided by LEGACY, Inc.

HIPAA Required Statements:
I understand that the information provided under this release may be subject to re-disclosure by the recipient under circumstances no longer protected by HIPAA Privacy Rules.

I understand that I may revoke this release at any time, except to the extent that action has already been taken to comply with it.

Acknowledgement of Notice of Privacy Practices (Please initial) ________

Athlete or Person Authorized to sign release for Athlete:

Athlete______________________________ Date ______________

Parent ______________________________ Date______________
Or
Legally Authorized Representative ______________________________ Date ________________