AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Name of Student Athlete_____ Date of Birth _____

1. I authorize the use or disclosure of the above named individual's health information by the QMG Sports Medicine Team as described below.
2. The type of information to be used or disclosed is as follows:
    a. Dates of medical services
    b. Emergency treatment information
    c. Results of diagnostic tests
    d. Physical Therapy and other rehabilitation information
    e. Condition and ability to participate
    f. All other medical information related to the student athlete's ability to participate in sports
3. The information identified above may be used or disclosed to the following organization's athletics staff:

_____

Organization

4. The information for which I am authorizing disclosure will be used for the sole purpose of providing training and safety advice and determining playing/practice participation status for the above named organization's sports.
5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
6. Without express written revocation, this authorization expires upon that date in which the student athlete named above is no longer enrolled in the organization authorized to receive this information.
7. I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and federal privacy laws or regulations may not protect the information.
8. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of student athlete or legal representative Date

_____

If signed by legal representative, relationship to patient

_____ _____

Signature of witness Date