Student-Athlete Authorization
For Disclosure of Protected Health Information

I, ____________________________ parent or guardian of ____________________________ (the "student athlete"), hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel representing Tallahassee Orthopedic Clinic, P.A., ("Health Care Personnel") to release information regarding the student-athlete's protected health information and related information regarding any injury or illness during the student-athlete's training for and participation in athletics at __________ __________ 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 health care providers, hospitals and/or medical clinics and laboratories, athletic coaches, athletic and/or school administrators, medical insurance coordinators, chaplains and/or clergy members, and officials of the Florida High School Activities Association, Inc. I also authorize the athletic coaches, athletic and/or school administrators, and medical insurance coordinators at the School ("School Officials") as well as chaplains and/or clergy members, and officials of the Florida High School Activities Association, Inc. to release protected health information and related information regarding any injury or illness during the student-athlete's training to the Health Care Personnel.

I understand that as a parent/legal guardian my authorization/consent to the disclosure of the student-athlete's protected health information is required so that Health Care Personnel and School Officials can freely and fully discuss any medical or condition that affects the student student-athlete's participation in interscholastic sports at the School, and that failure to sign this form may affect the ability of student athlete to participate in interscholastic sports at the School. I understand that the student-athlete's protected health information is protected under the federal Health Insurance Portability and Accountability Act ("HIPAA") and related regulations, and may not be disclosed without my consent. 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 HIPAA or federal law. I, the parent/legal guardian, understand that I may refuse to sign this authorization, but, if I do, the School's athletic trainer or physician is not allowed to discuss your son/daughter's treatment information with any person other than the parent or guardian. I may revoke this authorization at any time by notifying the School's 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 from the date it is signed.

I may request a notice of the complete description of such uses and disclosures prior to signing this consent. I am aware that the Leon County School District may change the terms of the notice at any time, and I reserve the right to request a revised notice.

I have the right to request that the Leon County School District and/or Health Care Personnel restrict how protected health information is used or disclosed to carry out treatment, payment or health care operations of my child. I understand that Leon County School District and/or Health Care Personnel are not required to agree to the requested restrictions; however, if the Leon County School District and/or Health Care Personnel do agree to a requested restriction, the restriction is binding on the Leon County School District or Health Care Personnel as the case may be.

____________________________ ____________________________
Print Student-Athlete Name Signature of Parent/Legal Guardian

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Date