Authorization to Disclose Health Information

Athlete's Name: _____ Date of Birth: _____

I authorize MCG Health, Inc. dba Augusta University Health to use or disclose the above named individual's health information as described below, concerning the period from 07/31/2017 to 07/31/2018.

_ Medical information, as specified:
X Standard Document Set (Discharge Summary, History and Physical, Progress Notes, Test Results, Consults)
X Other (specify): **Pre-Participation Exam and any subsequent athletic injury**
_ Entire Medical Record (justification required)
_ Psychiatric/Psychological Information
_ Drug/Alcohol Abuse Treatment Information
_ HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome)

This information may be disclosed to and used by the following individual or organization:

Name: Athletic Department & School Administration at Midland Valley High School
***Teachers on an as needed basis

Address: 227 Mustang Drive
Graniteville, SC 29829
Phone 803-593-7100
Fax 803-593-7106

Purpose: To assist the coaches, athletic director, and school administration in understanding the athlete's ability to participate in athletics.

Special Instructions: Only coaches from the particular sport, Athletic Director, and School Administration at Midland Valley High School may receive this information.

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 health information management department. I understand that the 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. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: **07/31/2018**. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information Management Services at (706) 721-2722.

_____ _____
Parent or Legal Representative Signature Date

_____ _____
If signed by Legal Representative, Relationship to Athlete Signature of Witness