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.,/TOSPT ("Health Care Personnel") to release information regarding the student-athlete's protected health information and related information regarding any injury or illness during the students-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-athlete's participation in inter-scholastic sports at the School, and the failure to sign this form may affect the ability of the 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 HIPPA or federal law. I, the parent/legal guardian, understand that I may refuse to sign the 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 affect 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's Name Signature of Parent/Legal Guardian

_____

Date