ORTHO ARKANSAS

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize OrthoArkansas to use and/or disclose certain protected health information (PHI) about me to:

Athletic Department Staff at: **Harmony Grove School District**

This authorization permits OrthoArkansas to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

Information concerning the condition and treatment of injuries sustained at school sports functions to include athletic department activities, cheerleading, drill team, band.

The information will be used or disclosed for the following purpose:

Athletic Sports Programs.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

I do not have to sign this authorization in order to receive treatment from OrthoArkansas. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. This practice may in some cases receive payment for disclosing this patient's protected healthcare information. My written revocation must be submitted to the Privacy Officer at OrthoArkansas, 800 Fair Park, Little Rock, AR 72204.

_____ _____

Student Name Student Date of Birth

X_____

Signature of Parent or Legal Guardian Print name Date