



**Protected Health Information Authorization**      Year \_\_\_\_\_

**For Release of Information**

**School:** \_\_\_\_\_

**I hereby authorize any medical provider associated with my school/organization, specifically PlaySafe to use and/or disclose my clearance and health recommendations to the athletic director, coaches, athletic trainers and medical personnel at my school/organization to inform them of my health status for the participation in athletics or activities. I understand that my refusal to sign this authorization may affect my child's ability to participate in athletics. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the state or federal law.**

**Athlete's Printed Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Athlete's Signature if 18 or older:** \_\_\_\_\_

**Parent's Printed Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Parent/Guardian Signature:** \_\_\_\_\_