



Athlete Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Mother's Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Father's Phone: \_\_\_\_\_

Parent Email: \_\_\_\_\_

Sports: \_\_\_\_\_

Last Year's School Attended: \_\_\_\_\_

Witham Health Services provides certain medical services to athletic programs. Witham Health Services is required by law to obtain this authorization before the organization can disclose your protected health information to your school. This form is required before medical services can be served to the athlete.

**The use and/or disclosure being authorized:**

Protected health information to be used and/or disclosed: The protected health information to be used or disclosed to the school athletic training or coaching staff by Witham Health Services includes any and all medical data. Documents or consultation reports related to the athlete's physical fitness, ability to return to practice, or ability to engage in any school related sport(s) are protected by this agreement.

Purpose of this Authorization/Entities Authorized: By signing this form, you authorize us to disclose to the athletic training staff, coaching staff, athletic director, and teaching staff the protected health information described above to enable the school to determine the athlete's fitness to practice and participate in school sports.

**No Conditions: This authorization is voluntary. We will not condition treatment on receiving this authorization.**

Effect of Granting this Authorization: The protected health information described above may be disclosed to and/or received by individuals or organizations who are not subject to federal health information privacy laws. These individuals or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

**Expiration and Revocation.**

Expiration: This authorization will expire upon (a) the termination of the athlete's eligibility to participate in school sports, according to school and IHSAA policies, as amended from time to time or (b) revocation of the authorization of this authorization.

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to the contact listed below. Revocation of this authorization will not affect any action we took in reliance on this authorization before we received your written notice of revocation. Witham Health Services will inform your school of any revocation of this authorization.

**Individuals Signature:** I acknowledge and agree that (a) I have had full opportunity to read and consider the contents of this authorization and (b) the information provided is accurate. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of protected health information, as described in this form. **You are entitled to a copy of this authorization after you sign it.**

Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Relationship to Athlete: \_\_\_\_\_

**Acknowledgement of Receipt of Notice of Privacy Practices Form:** Details are contained in the Athletic handbook. By signing below, I hereby acknowledge the receipt of Witham Health Services Notice of Privacy Practices.

Print Name: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_