Little Rock School District

Athletic Director-Secondary Schools
3615 West 25th Street
Little Rock, AR 72204
(501) 447-2060

I, ______________________________ , parent or guardian of ________________________ , hereby authorize my primary care provider, and the physicians, athletic trainers, sports medicine staff, school nurses and other health care personnel representing the Little Rock School District, in partnership with Arkansas Children's Hospital, to release protected health information regarding any annual evaluations (physicals) or health summaries, and any injury or illness during training and participation in extracurricular athletics. This protected health information may be released to other health care providers, and members of the treatment team, for the purpose of caring for my child/athlete. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. The treatment team may include patient/guardians, hospitals, and or medical clinics, and laboratories, athletic coaches, strength and conditioning coaches, medical insurance coordinators, insurance carriers, medical supply vendors, academic counselors, athletic and school administrators, chaplains and or clergy members.

I understand that my authorization/consent for the disclosure of my protected health information is a condition for participation as an athlete for the Little Rock School District. I understand that my protected health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPPA) or the Family Educational Rights and Privacy Act of 1974 (The Buckley Amendment) and may not be disclosed without either my authorization under HIPPA or my consent under the Buckley Amendment. **I understand that once the information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPPA and/or the Buckley Amendment**.

I understand that I may revoke this authorization at any time by notifying in writing the Head Athletic Trainer, but if I do, it will not have any effect on actions of the Little Rock School District taken in reliance on this authorization/consent prior to receiving this revocation. This authorization/consent expires (1) year from the date it is signed.

Athlete's Name ________________________________ DOB ____________________

Signature ________________________ Email Address ________________________________ Phone # ___________

Parent/Guardian's Name ______________________________________ Email address __________________________

Signature ______________________________ (parent) Signature ____________________________ (parent)

Mother's First Name ____________________ Father's First Name ___________________________

Mother's Phone # ______________________ Father's Phone # ______________________________

Current Primary Care Provider or Practice ____

Insurance Companies ____