Emory Sports Medicine

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Emory Sports Medicine team physicians and athletic trainers to release information concerning any illness or injury relative to my participation in athletics at Chattahoochee High School to athletic coaches, administrators, and sports information staff for legitimate educational purposes related to my participation in those sports.

I understand that I cannot participate in my sport without signing this release, and that this release will be effective for the time period of my participation in athletics at Chattahoochee High School.

NOTICE

Emory Sports Medicine and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state and federal confidentiality laws.

PATIENT RIGHTS

- I understand the treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment (for which I would be notified), 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to the Head Athletic Trainer. The revocation will take effect when Emory Sports Medicine receives it, except to the extent that Emory Sports Medicine or others already relied on it.
- I am entitled to receive a copy of this Authorization.

SIGNATURE

_____

Print Name

_____

Signature

_____

Parent signature if under 18

_____

Sport

_____

Date