LITTLE ROCK CHRISTIAN HIPPA FORM

AUTHORIZATION FOR USE OF DISCLOSURE OF HEALTH INFORMATION (HP 6.0.f3)

I_____hereby authorize the use and disclosure of individually
(Printed name of parent/guardian)
identifiable health information relating to my minor child, _____
(Printed name of minor child)
which is called "Protected Health Information" under a federal health privacy law, as described below:

PLEASE INITIAL EACH SECTION

A. The "Protected Health Information" (P.H.I.) will include but is not limited to preparticipation physical evaluation, evaluation information, and rehabilitation information. The P.H.I. can be in the form of a personal conversation and /or written report.
Please Initial:_____

B. The primary care physician and certified athletic trainer will be authorized to use or disclose the "Minor Child's" health information (P.H.I.) **Please initial:_____**

C. The coaching staff, athletic director, and administration personnel will be authorized to obtain health information (P.H.I.) from the above persons. **Please initial:_____**

The health information (P.H.I.) will be used and/or disclosed for the purpose of this ability to provide accurate and complete medical coverage for the "Minor Child".

Please indicate if any part of the "Minor child's" health information (P.H.I.) should be excluded and I or authorized personnel described above should be excluded from using the "Minor Child's health information (P.H.I.).

• I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulation, the released information may be re disclosed by the recipient and may no longer be protected by federal or state law.

• I understand that I may revoke this authorization at any time by notifying LRCA's Trainer. However, if I choose to do so, I understand that my revocation will not affect any action taken by LRCA's Trainer before receiving my revocation.

• I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment.

_____ _____ _____
Signature of Parent/Guardian Date