STUDENT ATHLETE PRIVACY FORM

Authorization for

Disclosure of Protected Health Information

I, _____, parent or guardian of _____ (the "student athlete"), hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel represent CHRISTUS Health System, including CSM, to release information regarding the student athlete's protected health information and related information regarding any injury or illness during the student athlete's training for participation in athletics at _____ School (the "School"). This protected health information may concern the student athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related individually identifiable health information. This protected health information may be released to other health care providers, hospitals, or medical clinics, Saturday Morning Clinics, and laboratories, athletic coaches, medical insurance coordinators, athletic and/or school administrators, chaplains, and/or clergy members, and officials of _____College and the _____ school district.

I understand that as a parent/legal guardian my authorization/consent to the disclosure of the student athlete's protected health information is a condition for the athlete's participation in interscholastic sports at the School. I understand that the student athlete's protected health is protected under federal law. I, the parent/legal guardian, understand that once the information is disclosed per this authorization, the information is subject to re-disclosure by the recipient and may no longer be protected under federal law. I may revoke this authorization at any time by notifying the School's athletic director in writing, but if I do, it will not have any effect on actions taken in reliance of my prior authorization. This authorization expires one year from the date that it is signed.

REQUIRED SIGNATURE FOR PARTICIPATION FOR INTERSCHOLASTIC SPORTS

_____ _____

Printed Student Athlete Name Signature of Parent/Legal Guardian

_____

Date

NOTICE OF PRIVACY PRACTICES

By signing above I acknowledge that I have received or have been offered a copy of CHRISTUS Trinity Mother Frances Health System's Notice of Privacy Practices.