Tennessee Orthopaedic Alliance

www.toa.com

I hereby authorize the Certified Athletic Trainers, Physicians, and/or other health care personnel representing Tennessee Orthopaedic Alliance to gather and release the student-athlete's protected health information and any related information related to any injury or illness regarding preparation and participation for athletic activities at the athlete's school. This information can be shared to determine the athlete's ability to participate in activities. This protected healthcare information may be obtained or released to other healthcare providers, hospitals/medical clinics, laboratories, Certified Athletic Trainers, Physicians, athletic coaches, school administrators, and other health care personnel representing Tennessee Orthopaedic Alliance.

I understand that as a parent/legal guardian that I may revoke this authorization/consent at any time by notifying in writing to the school's athletic director. I understand that the athlete's information is protected by Federal Law. In the event that I revoke this authorization/consent, it will not have any effect on actions taken prior to the revocation. This authorization/consent expires one year and ninety (90) days from the date of signature.

I have read and understand the information above.

SIGNATURE REQUIRED FOR AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

____

Print Student Athlete's Name

__________________________________ __________________

Signature of Parent/Legal Guardian Date Signed