

MONTGOMERY ACADEMY
STUDENT-ATHLETE AUTHORIZATION
FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
2010-2011

I hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel representing Jackson Hospital Sports Medicine and/or _____ (please list your preferred physician or hospital) 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 and participation in athletics at The Montgomery Academy. I further understand that it is at my request to comply with the requirements of the school and release of protected health information to a coach, athletic director or school official in connection with participation in interscholastic sports. This protected health information may concern the student-athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be released to other health care providers, hospital and/or medical clinics and laboratories, athletic coaches, medical insurance coordinators, athletic and school administrators, chaplains and/or clergy members or officials of the Alabama High School Athletic Association.

I _____ (parent/guardian) of _____ (student) understand that as a parent/legal guardian, giving authorization/consent for the disclosure of the student-athlete's protected health, is a condition for participation as an interscholastic athlete at The Montgomery Academy. I understand that my protected health information is protected by the federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without parent/legal guardian authorization under HIPAA or consent under the Buckley Amendment. I, the parent/legal guardian, understand that once information is disclosed per authorization or consent, the information is subject to re-disclosure and may no longer be protected by HIPAA or the Buckley Amendment. I, the parent/legal guardian, understand that I may revoke this authorization consent at any time by notifying in writing the school's athletic director. I also understand, that if I choose to do this, it will not have any effect on the action The Montgomery Academy school officials took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent expires one year from the date it is signed.

Please understand that Jackson Hospital Sports Medicine is listed because they, through Rehab Associates, provide the athletic trainers at our athletic contests. In order for them to be able to address an injury with a coach or school official during a contest, they must be listed. Our coaching staff has been instructed not to suggest sources for medical treatment unless asked by a parent/legal guardian. We do not send athletes to certain physicians or medical facilities without a parent/legal guardian's consent or request. In every case of an injury, barring emergencies, the parents are notified and instructions are requested.

REQUIRED SIGNATURE FOR PARTICIPATION IN INTERSCHOLASTIC SPORTS

Print Student-Athlete Name

Signature of Parent/Legal Guardian

Date