

THE D A CARE™

AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

Photocopy or facsimile of the original authorization will be considered as valid as the original

ATHLETE

Athlete's Name

Date of Birth

Street Address

City /State/Zip Code

AUTHORIZES:

INFORMATION TO BE RELEASED FROM:

THEDACARE

Name of Health Care Provider/Plan/Other

122 E. College Ave.

Street Address

Appleton, WI 54911

City/State/Zip Code

INFORMATION RELEASED TO:

Officials of the school I attend. This would include all coaching staff and athletic directors who are involved in my sporting events at

Name of Receiver Fox Valley Lutheran High School

5300 N Meade Street

Street Address

Appleton, WI 54913

City/State/Zip Code

INFORMATION TO BE RELEASED INCLUDES:

X All information concerning my health that impacts my ability to participate in sports. This may include information about injuries (such as sprains, strains), surgeries (such as ACL reconstruction, rotator cuff repair), concussions (ImPACT test results) or medical conditions (such as asthma).

NEED FOR THE DISCLOSURE:

X The purpose of the release of this information is:

- To inform the coaching staff of my health-related limitations and abilities to continue to participate in sporting events.
- To provide the coaching staff with information about my injury to help me participate in sporting events safely.

I understand that if the person(s) and/or organization listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be used or disclosed—I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department. **Right to Receive Copy of this Authorization**—I understand that if I agree to sign this authorization, which I am not required to do so, I must be provided with a signed copy of the form. **Right to refuse to sign this authorization**—I understand that I am under no obligation to sign this form and that the person(s) and or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw this Authorization**—I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health information department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good for one year from the date signed. I have had opportunity to review and understand the content of this authorization form. By signing this authorization I am confirming that it accurately reflects my wishes.

SIGNATURE OF ATHLETE/LEGAL REPRESENTATIVE: _____

DATE: _____ (If signed by other than the patient, state relationship and authority in which to sign for the patient, i.e. deceased, minor, incompetent)

Request filled by: _____ (Employee) Date: _____ Records Released: _____