METHODIST SPORTS MEDICINE CENTER
AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION
RELEASE OF RECORDS

First Name: _____ M.I. _____ Last Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Date of Birth: _____

IF YOU ARE NOT AN ATHLETE INVOLVED IN A SCHOOL SPORT PROGRAM, SKIP SECTION A

SECTION A: SPORTS AUTHORIZATION

Protected health information to be used and/or disclosed: The protected health information to be used or disclosed by Methodist Sports Medicine Center includes any and all medical data, documents, or consultation reports related to the athlete's physical fitness to practice or to engage in any school-related sport(s).

Purpose of this Authorization/Entities Authorized: By signing this form, you authorize us to disclose to _____ (name of school) and its coaches, athletic trainers, athletic director, and staff the protected health information described above to enable the school to determine the athlete's fitness to practice and participate in school sports.

Expiration: This authorization will expire upon (a) the termination of the athlete's eligibility to participate in school sports, according to school and IHSAA or other National Federation of State High School Association's member's policies, as amended from time to time or (b) revocation of this authorization as described below.

SECTION B: FAMILY AUTHORIZATION

Protected health information to be used and/or disclosed: The protected health information to be used or disclosed by Methodist Sports Medicine Center includes any and all medical data, and appointment or billing information related to your treatment by Methodist Sports Medicine Center.

Entities Authorized: By signing this form, you authorize us to disclose the above-referenced information to your immediate family, including but not limited to, your parents, your spouse, and your adult-aged children.

Expiration: This authorization will remain in effect until my treatment and patient account have been resolved.

SECTION C: CONDITIONS

No Conditions: This authorization is voluntary. We will not condition treatment on receiving this authorization.
Effect of Granting this Authorization: The protected health information described above may be disclosed to and/or received by individuals or organizations who are not subject to federal health information privacy laws. These individuals or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

SECTION D: REVOCATION

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to the contact listed below. Revocation of this authorization will *not* affect any action we took in reliance on this authorization before we received your written notice of revocation. Methodist Sports Medicine will inform your school of any revocation of this authorization.

Contact Information: Privacy Official
Methodist Sports Medicine
201 Pennsylvania Pkwy, Suite 100, Indianapolis, IN 46280
Telephone: 317-817-1200

SECTION E: INDIVIDUAL'S SIGNATURE

I acknowledge and agree that (a) I have had full opportunity to read and consider the contents of this authorization and (b) the information provided above is accurate. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of protected health information, as described in this form.

Signature of Patient: _____

Signature of Personal Representative (if patient is a minor): _____

Relationship to Patient: _____

Date: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.