# AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization for release of protected health information is provided by OrthoSouth. Please see the Patient Notice for information regarding how your medical information may be used or disclosed.. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Compliance Officer of OrthoSouth. The Notice is also posted at OrthoSouth offices and on the OrthoSouth website.

- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED .**
- **WE WILL NOT CONDITION YOUR TREATMENT ON THIS AUTHORIZATION.**
- **WE WILL PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.**

***THIS AUTHORIZATION IS VOLUNTARY***

**TO BE COMPLETED BY STUDENT OR PARENT/LEGAL GUARDIANCE**

I, (Print Student's Name)_____, Date of Birth_____
do hereby authorize OrthoSouth to obtain, use, disclose or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that information released under this authorization may be redisclosed by the recipient of the information and may no longer be protected by state and federal law.

I hereby authorize OrthoSouth to release my medical information and related information regarding my physical condition or regarding any injury, illness or condition that I sustain due to my involvement in activities at my school, _____to a coach, team member, administrative staff of my school, family member or legal guardian for purposes of enhancing my safety in connection with my participation or presence at school-related activities and to establish open lines of communication regarding my medical condition and status. I understand this information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information.

I understand that I may withdraw my authorization in writing to the Compliance Officer of OrthoSouth at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire **upon the later date of my graduation or the completion of my participation in school-related events.** I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

***Signatures: All students must sign this consent. If the student is under 18 years of age at the time of signature, a parent or legal guardian must sign this authorization as well. By signing this authorization, the student understands that it will continue to be in effect upon the student turning 18 years of age.***

I, _____, parent and/or legal guardian of _____, student, acknowledge that I am authorized to provide my consent and by signing this form provide my authorization and consent for the release of protected health information of the above named student for the limited purposes described above.

_____ DATE: _____

Please Print Signatory's Name:_____

Address: _____

Relationship to Student (if Student is under 18 years of age): _____

Student's Signature: _____

Please Print Student's Name: _____