**Authorization to Disclose Health Information**

Athlete’s Name: Date of Birth:

**I authorize AU Medical Center, Inc. to use or disclose the above named individual’s health information as described below, concerning the period from July 1, 2023 to June 30, 2024**.

\_ Medical information, as specified:

\_ Standard Document Set (Discharge Summary, History and Physical, Progress Notes, Test Results, Consults)

**X** Other (specify): **Pre-Participation Exam and any subsequent athletic injury or condition**

\_ Entire Medical Record (justification required)

\_ Psychiatric/Psychological Information

\_ Drug/Alcohol Abuse Treatment Information

\_ HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome)

**This information may be disclosed to and used by the following individual or organization (circle ONE):**

**Name**: Academy of Richmond County **Name**: Hephzibah High School

**Address**: 910 Russell St., Augusta, GA 30904 **Address**: 4558 Brothersville Rd., Hephzibah, GA 30815

**Name**: Butler High School **Name**: T.W. Josey High School

**Address**: 2011 Lumpkin Rd., Augusta, GA 30906 **Address**: 1701 15th St., Augusta, GA 30901

**Name**: Cross Creek High School **Name**: Lucy C. Laney High School

**Address**: 3855 Old Waynesboro Rd., Augusta, GA 30906 **Address**: 1339 Laney Walker Blvd., Augusta, GA 30901

**Name:**  Davidson Fine Arts Magnet School **Name**: RCTCM School

**Address:** 615 12th St., Augusta, GA 30901 **Address:** 3200B Augusta Tech Drive, Augusta, GA 30906

**Name**: Glenn Hills High School **Name**: Westside High School

**Address**: 2840 Glenn Hills Dr., Augusta, GA 30906 **Address**: 1002 Patriot’s Way, Augusta, GA 30907

**Name:** AR Johnson Health Science & Engineering Magnet School

**Address**: 1324 Laney Walker Blvd, Augusta, GA 30901

**Purpose**: To assist the coaches, school administration, and Richmond County Board of Education with the athlete’s ability to participate in athletics

**Special Instructions**: Only coaches from the particular sport or Athletic Director, School Administration may receive this information.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: **06/30/24**. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information Management Services at (706) 721-2722.

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 Parent or Legal Representative Signature Date

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 If signed by Legal Representative, Relationship to Athlete Signature of Witness