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, 2024 to June 30, 2025.

_ 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
Address: 910 Russell St., Augusta, GA 30904

Name: Hephzibah High School
Address: 4558 Brothersville Rd., Hephzibah, GA 30815

Name: Butler High School
Address: 2011 Lumpkin Rd., Augusta, GA 30906

Name: T.W. Josey High School
Address: 1701 15th St., Augusta, GA 30901

Name: Cross Creek High School
Address: 3855 Old Waynesboro Rd., Augusta, GA 30906

Name: Lucy C. Laney High School
Address: 1339 Laney Walker Blvd., Augusta, GA 30901

Name: Davidson Fine Arts Magnet School
Address: 615 12th St., Augusta, GA 30901

Name: RCTCM School
Address: 3200B Augusta Tech Drive, Augusta, GA 30906

Name: Glenn Hills High School
Address: 2840 Glenn Hills Dr., Augusta, GA 30906

Name: Westside High School
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: **06/30/25**. 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.

_____ _____
Parent or Legal Representative Signature Date

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