Authorization to Disclose Health Information

Athlete's Name: Date of Birth:

I authorize Wellstar MCG Health. to use or disclose the above named individual's health information as described below, concerning the period from July 1, 2025 to June 30, 2026.

_ 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:

Name (Circle One): Richmond County Board of Education and the school of the following which I attend: Academy of Richmond County, Butler High School, Cross Creek High School, Glenn Hills High School, Hephzibah High School, T.W. Josey High School, Lucy C. Laney High School, Westside High School

Purpose: To assist the coaches and school administration 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: **06/30/26**. 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