STUDENT ATHLETE AUTHORIZATION & CONSENT FORM

I,__________________________the parent or guardian of_________________________a student-athlete participating in interscholastic athletic sports, understand that the disclosure of the student-athlete's protected health information is a condition of participation at Lebanon Junior and Senior High School.

I hereby authorize/consent for physicians covering Lebanon Junior and Senior High School's athletic events and Memorial Hospital's Certified Athletic Trainer and other health-care personnel participating with Lebanon Junior and Senior High School's athletic program to release information regarding my student athlete's protected health information (PHI) and related information regarding any injury or illness which may occur during the student-athlete's training for and participation in athletics at Lebanon Junior and Senior High School to any coach, athletic director, or school official in connection with my student's participation in interscholastic sports. This protected health information may concern the student-athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status and related personally identifiable health information. This protected information may be released to other health-care providers, hospital *and/or* medical clinics and laboratories, athletic coaches, athletic trainers, medical insurance coordinators, athletic and/or school administrators, and officials of the student-athlete's sport.

I understand that my student-athlete's protected health information may be protected by federal regulations under the Health Information Portability and Accountability Act (HIPAA) and, if so, may not be disclosed without parental/legal guardian's authorization.

I understand as parent or guardian of the student-athlete:

- This authorization/consent is valid for the duration of the school year of the student-athlete, unless I rescind my permission in writing to Lebanon Junior and Senior High School, 200 W. Schuetz St., Lebanon, IL 62254.
- A revocation will not affect any uses or disclosures that the School, BJC Medical Group of Illinois physicians, and Memorial Hospital's Certified Athletic Trainer made before it received my student's revocation.
- If I request it, I may see a copy of the PHI described on this form.
- The information that is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. I have the right to seek assurances from the above named entities or individuals authorized to receive the information that they will not re-disclose information to any other party without my further authorization.

__________________________	__________________________	________________
Print Student-Athlete's Name	Student-Athlete's Signature	Date
__________________________	__________________________	________________
Print Parent/Guardian's Name	Parent/Guardian's Signature	Date