Student-Athlete Authorization
For
Disclosure of Protected Health Information

I hereby authorize the physicians, athletic trainers, physical therapists and sports medicine personnel representing Campbell Clinic to disclose protected health information regarding any injury or illness affecting the student-athlete's training for and participation in athletics at **Fayette Academy**. Campbell Clinic is authorized to disclose this protected health information to any coach, the athletic director, or any school official in connection with his/her participation in interscholastic sports. This protected health information may concern the student-athlete's medical status, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be disclosed to other health care providers within the Campbell Clinic system; to **Fayette Academy** Administrators; and to officials of the Tennessee Secondary School Athletic Association.

I, _____, parent or guardian of _____,
(name of parent/guardian) (name of student)
understand that parent/legal guardian authorization/consent for the disclosure of the student-athlete's protected health information is a condition for participation as an interscholastic athlete at **Fayette Academy** and for care during interscholastic athletics. I understand that my child's protected health information is protected by the federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment). This protected health information may not be disclosed without parent/legal guardian authorization under HIPAA or consent under the Buckley Amendment. I, the parent/legal guardian, understand that once information is disclosed per authorization or consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I, the parent/legal guardian, understand that I may revoke this authorization/consent at any time by notifying in writing Campbell Clinic. If authorization or consent is revoked, it will not have any effect on the actions Campbell Clinic personnel took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent is enacted on the date of signature and expires on May 31, 2019. Campbell Clinic will not condition your treatment on the signing of an authorization, except for any possible research-related treatment.

REQUIRED SIGNATURE FOR PARTICIPATION FOR INTERSCHOLASTIC SPORTS

_____ _____
Print Student-Athlete's Name **Signature of Parent/Legal Guardian**

_____
Date