Student-Athlete Authorization
For
Disclosure of Protected Health Information

I hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel from Jackson-Madison County General Hospital District d/b/a Sports Plus/LIFT Therapy ("Sports Plus/LIFT Therapy") to release and disclose all information regarding the below-named student-athlete's protected health information and related information regarding any injury or illness occurring during such student-athlete's training for and participation in athletics at _____ School. This protected health information that may be disclosed includes the student-athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, payment information, prognosis, and related personally identifiable health information. This protected health information may be released to other health care providers, hospital and/or medical clinics and laboratories, athletic coaches, medical insurance coordinators, athletic and/or school administrators, chaplains and/or clergy members, and governmental or school officials. The disclosure and release of the foregoing information is at my/our request.

I, _____ parent or guardian of _____
(name of parent/legal guardian) (name of student athlete)
understand that my giving authorization/consent for the disclosure of the student-athlete's protected health information is a condition for participation as an interscholastic athlete at _____ School for the purpose of the undersigned student-athlete's participation in interscholastic sports. I understand that the student-athlete's protected health information is protected by the federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either parent/legal guardian authorization under HIPAA or consent under the Buckley Amendment, except in certain circumstances set forth in those laws. I, the parent/legal guardian, understand that once information is disclosed per this Authorization, the information is subject to redisclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I, the parent/legal guardian, understand that this Authorization is voluntary, that I may refuse to sign this Authorization, and that I may revoke this Authorization at any time by notifying Sports Plus/LIFT Therapy in writing, but if I do, such revocation will not have any effect on the actions that Sports Plus/LIFT Therapy took in reliance on this Authorization prior to receiving the revocation. This Authorization expires one year from the date it is signed.

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

_____
Date

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received Sports Plus/LIFT Therapy's Notice of Privacy Practices.

_____ _____

Parent/Legal Guardian Signature Date

Release and Waiver

The purpose of this release is to authorize Sports Plus/LIFT Therapy to provide any emergency medical care, standard preventive care, and evaluation and treatment of injuries that may become reasonably necessary for the student in the course of school athletic activities or school travel.

I, _____, parent or guardian of _____ recognize that as a result of the student-athlete's participation in sports activities, medical treatment on an emergency basis may be necessary and standard treatment to prevent and treat injuries. I authorize and consent to Sports Plus/Lift Therapy to provide normal preventative care, such as but not limited to, taping of joints, stretching of muscles, and applying topical medications.I also authorize and consent to Sports Plus/Lift Therapy evaluating injuries and providing necessary treatments, such as but not limited to, exercises, modalities, and hot or cold therapy. I further recognize that school personnel may be unable to contact me for my consent for emergency medical care. In the event of any emergency, I authorize Sports Plus/LIFT Therapy to secure any treatment deemed reasonable and necessary, and agree that I will be responsible for payment of any and all medical services rendered. I understand that Sports Plus/LIFT Therapy will not be responsible for any medical costs associated with any injury sustained or aggravated while participating in sports activities. I hereby agree to indemnify and hold harmless Sports Plus/LIFT Therapy from any loss, liability, damage or costs that I may incur due to or arising from the student-athlete's participation.

_____ _____

Parent/Legal Guardian Signature Date