CONSENT FOR SPORTS PHYSICAL
AND AUTHORIZATION FOR RELEASE OF INFORMATION

Student-Athlete Name: _____
(Please Print)

School: _____

CONSENT. I hereby grant permission to W.A. Foote Memorial Hospital d/b/a Henry Ford Jackson Hosptial ("HFJH") to render to myself/my child a sports physical screening exam. I understand that this is a sports physical screening exam and that it is not a comprehensive exam and is not intended to provide treatment nor to create a physician/patient relationship. I understand that athletic participation comes with the risk of injury. This physical exam cannot detect all problems or prevent injury from athletic participation. I understand that if follow-up evaluation is recommended, it is my responsibility to seek care from an appropriate provider.

AUTHORIZATION FOR RELEASE OF INFORMATION. I hereby authorize the disclosure of my/my child's individually identifiable health information as described below. ***I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.***

Persons/organizations authorized to release student-athlete's individually identifiable health information include the following: The above referenced School (hereinafter "School") Athletic Trainer(s), Team Physician(s)/Consultant(s), and HFJH.

Person/organizations authorized to receive student-athlete's individually identified health information include the following: School Trainer(s), Team Physician/Consultant(s), HFJH, parents/guardians of the above referenced student-athlete, School coaches, and representatives of School's administration.

Description of information to be disclosed: All information relating to and including all injuries, illnesses and/or conditions of the student-athlete and any and all related medical information that may have resulted from, or may be connected with, the student-athlete's sports physical.

Reasons for disclosure: To communicate information about the student-athlete between School Athletic Trainer(s), Team Physician(s)/Consultant(s), and HFJH about the student-athlete's health status and injury/illness as determined by a sports physical exam. Further, to notify, inform, and advise the student-athlete's parents/guardians, School coaches, and School administration about the status of the student-athlete's physical condition(s) as determined by a sports physical.

I have read and understand the following statements:

- I may revoke this authorization at any time prior to its expiration date by providing written notification. However, I understand that revocation will not apply to information that has already been disclosed in response to this authorization.
- Upon request, I may see and copy the information described on this form.
- I understand that information used or disclosed as the result of this authorization and release may be re-disclosed by the person/entity receiving the information.
- This authorization will expire one (1) year after the date of signature.

Privacy Notice Acknowledgement: I acknowledge that a copy of the Privacy Notice was made available to me.

I declare that I have read, understand, and agree to the contents of this Consent for Treatment and Authorization for Release of Injury or Illness Information in its entirety.

Signature of Student-Athlete _____ Date:_____

Signature of Parent/Guardian _____ Date:_____
***Parent/Guardian signature required if Student-Athlete is under 18 years of age.**

Relationship to Student-Athlete: _____