BEACON
Orthopaedics & Sports Medicine

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

I hereby authorize Beacon Orthopaedics & Sports Medicine, Ltd. to release and disclose personal health information of _____ Beacon Orthopaedics & Sports Medicine, Ltd **("Student")**, as described below, to **LASALLE HIGH SCHOOL ("School").** ***(PLEASE PRINT)***

The information described below may be released to the School athletic director, coach, **certified athletic trainer (DAN FORCUM, employee of Beacon Orthopaedics or appropriate Beacon Orthopaedics representative),** school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including interscholastic sports programs.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to:

CEO OF BEACON ORTHOPAEDICS: **ANDY BLANKEMEYER**
ADDRESS: **BEACON ORTHOPAEDICS & SPORTS MEDICINE**
500 E-BUSINESS WAY
CINCINNATI, OH 45241

_____ **I REFUSE TO SIGN THE FORM.**

PLEASE NOTE: THIS AUTHORIZATION IS VALID FROM JULY 1, 2016 TO JUNE 30, 2017

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

_____
STUDENT'S SIGNATURE BIRTH DATE OF STUDENT, INCLUDING YEAR

NAME OF STUDENT'S PERSONAL REPRESENTATIVE: _____
I am the Student's (check one): _____ Parent _____ Legal Guardian (documentation must be provided)

_____
Signature of Student's personal representative, if applicable Date