



CARROLLWOOD DAY SCHOOL

**Athlete Authorization/Consent
for Disclosure of Protected Health Information**

I hereby authorize the Team Physicians, Certified Athletic Trainers, Sports Medicine Team, and other health care professionals representing Carrollwood Day School to release information regarding the athlete's protected health information and related information regarding any injury or illness during the athlete's training for and participation in athletics at Carrollwood Day School. I further understand that it is at my request to comply with the requirements of his/her school and release of protected health information to a coach, the Athletic Director, or school official in connection with participation in interscholastic sports. This protected health information may concern the 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, medical insurance coordinators, athletic and/or school administrators, and officials of the Florida High School Athletics Association.

I, _____, parent or guardian of _____, understand that as a parent/legal guardian giving authorization/consent for the disclosure of the athlete's protected health information is a condition for participation as an interscholastic athlete at Carrollwood Day School for the purpose of the undersigned athlete to participate in interscholastic sports. I understand that my athlete'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) and may not be disclosed without either 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 to the school's Athletic Director, but if I do, it will not have any effect on the actions Carrollwood Day School officials took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent expires at the end of each school year.

REQUIRED SIGNATURE FOR PARTICIPATION IN INTERSCHOLASTIC SPORTS

Printed Athlete Name

Signature of Parent/Legal Guardian

Date