



HENRY FORD ALLEGIANCE HEALTH

CONSENT FOR TREATMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

Student-Athlete Name: (Please Print)

School:

CONSENT. I hereby grant permission to the School Athletic Trainer, Team Physician, Team Consultant(s), and W.A. Foote Memorial Hospital d/b/a Henry Ford Allegiance Health (hereinafter "HFAH") to render to myself (or my child) any and all medical care deemed reasonably necessary.

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: School Athletic Trainer(s), Team Physician(s), Team Consultant(s), and HFAH.

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

Reasons for disclosure: To communicate information about the student-athlete between School Athletic Trainer(s), Team Physician(s), Team Consultant(s), and HFAH about the student-athlete's participation in School athletics, health status, and injury or illness. Further, to notify, inform, and advise the student-athlete's parents/guardians, School coaches, and School administrative representatives about the status of the student-athlete's physical condition(s) related to the student-athlete's participation in School athletics.

I have read and understand the following statements:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing. 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 am not required to sign this form to receive health care treatment, and I understand that my refusal to sign this form will result in my/my child not being permitted to participate in the School Athletic Program.
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.

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: