Witte PHYSICAL THERAPY

Blue Devils

Authorization to Disclose Private Health Information

I grant permission to Plattsmouth High School's Certified Athletic Trainers to disclose my Personal Health Information (written and/or verbal), when requested to do so, for the purposes of health care treatment, or for any other purpose which is permitted or required by law.

Personal Health Information includes but is not limited to: information involving the nature and treatment of an injury/illness, medical history, insurance coverage and copies of all hospital and medical records. This information will be released ONLY for the purposes of further treatment (referrals to specialists or other health care providers), disclosure of participation status to your team's coaches for your health and safety.

In order to maintain continuity of care and provide participation status updates to athletic department personnel, I hereby authorize the Certified Athletic Trainers to disclose injuries/illness contained in my student-athlete medical file, including medical conditions(s), treatment and rehabilitation status, and participation restrictions to the following entities:

a. Primary physician/Referring Physicians
b. Plattsmouth High School's Athletic Administration
c. **Parent/Guardian Name:** _____

This authorization expires one (1) year from the date signed. It may be revoked at any time provided written documentation of the revocation is on file in the athletic training room.

_____ _____

Students Name Students DOB

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature (if student-athlete is 18 or younger) Date