

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Tanner Health System, Inc., Tanner Medical Center, Inc. and/or Southern Therapy Services, Inc., ("Provider") together with its employees, agents, business associates and contractors, to use or disclose protected health information of _____ ("Patient") covered under privacy and security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (referred to as "HIPAA Privacy Rules") and/or protected under state law as provided in this Authorization. I understand information regarding alcohol and drug use, AIDs/HIV and other communicable diseases may be released.

Information to be Used/Disclosed: Entire examination record including pass or failure results from basic sports physical examination and corresponding diagnosis, medical information and follow-up recommendations or treatment plan

Recipient(s) of Use or Disclosure: This information may be disclosed to and used by the following persons or class of persons: Athletic Director of [INSERT SCHOOL] ("School") or School designee

Purpose(s) of the Use or Disclosure: At request of individual patient

Expiration: This Authorization expires upon graduation of Patient from School

How to Revoke This Authorization: I understand that I may revoke this Authorization by submitting a written revocation to Provider at _____, provided that such revocation shall not be effective with respect to any use or disclosure made by Provider in reliance on this Authorization prior to the date of receipt of my revocation.

Authorization is NOT a Condition to Examination: I understand that Provider cannot require me to sign this Authorization in order to receive examination. However, I will have to show proof of team eligibility directly to School if I am not willing to authorize direct disclosure of my results to School.

Potential Re-disclosure: I understand that the information used or disclosed by Provider pursuant to this Authorization may be subject to re-disclosure by the recipient of my information, in which case my records may no longer be protected by federal/state law.

Copy of Form: I understand that Provider must provide me with a copy of the signed Authorization.

I have read and understand this Authorization and my questions have been answered. I certify that I am the Patient listed above or a person authorized by law to permit release of records on behalf of Patient. I hereby release Provider and its employees, agents, business associates and contractors from any liability arising in connection with the use or disclosure of my information pursuant to this Authorization.

Print Name of Person Signing

Patient (if 18 or older) or Parent/Guardian

Date

Basis for Personal Representative's Authority to Sign (Example: Parent or Guardian)