



Athlete _____	School _____	Sport(s) _____
---------------	--------------	----------------

**Authorization to Release Medical Information**

I, \_\_\_\_\_, being the parent/legal guardian of \_\_\_\_\_ and residing at \_\_\_\_\_, do hereby authorize and consent to having Hughston Hospital's Athletic Trainers and/or their consulting physician(s) provide any requested medical information to other physicians, other healthcare providers, the high school coaches or school administration, or athletic trainers which directly pertains to my athletic participation at \_\_\_\_\_. Said authorization to release medical information will include, but is not necessarily limited to information concerning illnesses, injuries, treatments, hospitalizations, examinations, X-rays, or other forms of diagnostic testing occurring while participating in competitive athletics at said school or athletic organization.

I understand that I may revoke this authorization by providing written notice to Hughston Hospital. I also understand that if information has been released by relying upon this Authorization, that revocation will not be valid. I understand that injury treatment will not be conditioned upon signing this Authorization. I also understand that I am waiving my right to privacy with regard to the medical records and patient identifiable information by authorizing the release of my information.

I understand that the release of my medical information is being carried out with my consent and so assume full responsibility.

\_\_\_\_\_  
**Signature of Parent/Legal Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Student Athlete**

\_\_\_\_\_  
**Date**