HIPPA AUTHORIZATION

South Bend Orthopaedics and/or its Certified Athletic Trainer is authorized to disclose information regarding any injuries your child might receive during the course of the season, as well as the student's general fitness to play, to the student's coach, or any designated member of the coaching staff. I understand disclosure of health information carries with it the potential for re-disclosure by any recipients who are not subject to health privacy laws and that the student's health information, once disclosed, may no longer be protected by federal or state law.

I understand the Certified Athletic Trainer may communicate with the student's healthcare providers including, but not limited to, physicians and hospitals, regarding any injuries my child might receive during the course of the season, as well as his or her general fitness to play.

This authorization shall be in effect through the current school year. This authorization may be revoked in writing only. I understand this Authorization is voluntary and the Certified Athletic Trainer may not refuse to provide my child treatment if I do not sign this form.

_____ _____

Name of Student Date

_____ _____

Parent/Guardian Printed Name Parent/Guardian Signature

_____

Relationship to Student