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 Jackson Hospital (hereinafter "HFJH") to render to myself (or my child) any and all medical care deemed reasonably necessary. This includes preventative care, first aid, rehabilitation, and emergency care treatment, including, but not limited to, authorization for myself/my child to be hospitalized.

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 HFJH.

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), HFJH, 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 HFJH 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: _____

Emergency Contact Name and Phone Number: _____