Attachment A

AUTHORIZATION

Purpose: This form is used for an individual to authorize use or disclosure of the individual's protected health information for the purposes stated.

9. SECTION A: Student Information

Name:_____ DOB: _____

Address: _____ School: _____

City/State/Zip: _____ Telephone: _____

10. SECTION B: Consent to Treat

As a result of athletic/school participation, medical treatment may be necessary and I give consent to the Licensed Athletic Trainers from Aurora Sheboygan Memorial Medical Center to evaluate and treat any injuries, and activate emergency care as indicated within their scope of practice for my son/daughter.

11. SECTION C: Injury Information Release

I understand that as my child participates in activities, the Licensed Athletic Trainers from Aurora Sheboygan Memorial Medical Center may deem it necessary to inform the coach, physical education teacher or athletic director about my son or daughter's condition/injury. By signing this form, I agree to allow the Licensed Athletic Trainers to inform the coaches, physical education teacher and athletic director of the medical condition/injury pertaining to my son/daughter. I understand that should I have a potential concern about a medical condition/injury that I do not want discussed with the people stated above, I will need to inform the Athletic Trainer. If I wish this information to be discussed with any other people, I need to directly inform the Athletic Trainer.

12. SECTION D: Expiration and Revocation

This authorization will expire upon graduation from high school.

Right to Revoke: You may revoke this authorization at any time by providing verbal or written notice of revocation to Aurora Sheboygan Memorial Medical Center by calling (920) 451-5559 or sending it to Aurora Sheboygan Memorial Medical Center, ATTN: Rehabilitation Services, 2629 N. 7th Street, Sheboygan, WI 53083. Revocation of

this authorization will not affect any action we took in reliance on this authorization before we received your verbal or written notice of revocation.

****Parent/Guardian Signature (if athlete is under 18)**

I, _____, have had full opportunity to read
(Name of Parent/Guardian)
and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my child's protected health information, as described in this form.

Parent/Guardian Signature: _____ Date:_____

Relationship to Student: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include this authorization in the individual's records.

****Student Athlete's Signature (if athlete is 18 years of age)**

I, _____, have had full opportunity to read
(Athlete Name)
and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Student Athlete's Signature: _____ Date:_____

Verbal Authorizations:

_____
_____
_____
_____
_____
_____

I understand that a copy of Aurora Sheboygan Memorial Medical Center's Privacy Practices can be obtained by calling (920) 451-5559 or by mailing a request to Aurora Sheboygan Memorial Medical Center, 2629 N. 7th Street, Sheboygan, WI 53083.