

**METHODIST SPORTS MEDICINE / THE ORTHOPEDIC SPECIALISTS
COLLEGE ATHLETE
AUTHORIZATION FORM**

Purpose: Methodist Sports Medicine / The Orthopedic Specialists (MSM / TOS) provides athletic training and certain medical-related services to your school's athletic program. MSM / TOS is required by federal law to obtain this authorization before it can disclose your protected health information to your school. This form is used to authorize us to disclose protected health information to your school. Your authorization does not limit your right to choose your own physician for your own personal medical needs.

NOTE: Please Print. All information must be completed.

SECTION A: Athlete Information.

First Name: _____ M.I. _____ Last Name: _____

Date of Birth: _____ School Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ E-mail: _____
(optional)

SECTION B: Parent/Guardian Information.

Name: _____

Relationship to Athlete: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ E-mail: _____
(optional)

SECTION C: The use and/or disclosure being authorized.

Protected health information to be used and/or disclosed: The protected health information to be used or disclosed by MSM / TOS includes any and all medical data, documents, or consultation reports related to the athlete's physical fitness to practice or to engage in any school-related sport(s).

Purpose of this Authorization/Entities Authorized: By signing this form, you authorize us to disclose to the school named above and its coaches, athletic trainers, athletic director, and staff the protected health information described above to enable the school to determine the athlete's fitness to practice and participate in school sports.

No Conditions: This authorization is voluntary. We will not condition treatment on receiving this authorization.

Effect of Granting this Authorization: The protected health information described above may be disclosed to and/or received by individuals or organizations who are not subject to federal health information privacy laws. These individuals or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

SECTION D: Expiration and Revocation.

Expiration: This authorization will expire upon (a) the termination of the athlete's eligibility to participate in school sports, according to school and IHSAA policies, as amended from time to time or (b) revocation of the authorization of this authorization.

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to the contact listed below. Revocation of this authorization will *not* affect any action we took in reliance on this authorization before we received your written notice of revocation. MSM / TOS will inform your school of any revocation of this authorization.

Contact Information: Privacy Official
Methodist Sports Medicine / The Orthopedic Specialists
201 Pennsylvania Pkwy, Suite 200, Indianapolis, IN 46280
Telephone: 317-580-3515
E-mail: mbrennan@methodistsports.com

SECTION E: INDIVIDUAL'S SIGNATURE

I acknowledge and agree that (a) I have had full opportunity to read and consider the contents of this authorization and (b) the information provided above is accurate. I understand that, by signing this form, I am confirming my authorization for the use and /or disclosure of protected health information, as described in this form.

Signature of Patient: _____

Signature of Personal Representative (if patient is minor): _____

Relationship to Patient: _____

Date: _____

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