Authorization for Release Of Protected Health Information For Athletic Pre-Participation Physical Exams (HIPPA)

Athlete's Name: ________________________________ **Date of Birth:** _________ **Grade:** _________
Address: ____
High School: ____________________ **Sport**_________________

I, ________________________ (printed name of parent, legally authorized representative, or athlete if over 18) hereby authorize Allegheny General Hospital (AGH) and ________________________ High School to administer my son's/daughter's pre-participation physical examination, and/or I authorize the release of the pre-participation physical examination or a copy of this examination to: School Administration, Athletic Directors, Secretaries, Nurses, Coaches, Athletic Trainers and Team Physicians. The information being released is to inform the above-mentioned administration about the status of the pre-participation physical examinations.

This authorization is valid for 1 calendar year from the date below.

I understand that this authorization is subject to revocation at any time, except to the extent that Allegheny General Hospital has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set fourth above unless I revoke this authorization in writing to AGH (1307 Federal Street, Suite 500, Pittsburgh, PA 15212). Participants may re-disclose information with authorization.

Parent, Guardian, or Athlete (if over 18) Signature (if guardian, give relationship and authority to act)	Date	Witness

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Authorization for Consent of Treatment, by Certified Athletic Trainer(s)/ Team Physicians, Within The Scope of Practice

I, _________________________ (printed name of parent, legally authorized representative, or athlete if over 18) hereby authorize Allegheny General Hospital (AGH)Certified Athletic Trainer(s)/Team Physicians to provide only those services they are qualified through education or experience and which is allowed by their practice acts and other pertinent regulation.

This authorization is valid for 1 calendar year from the date below.

I understand that this authorization is subject to revocation at any time, except to the extent that Allegheny General Hospital has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set fourth above unless I revoke this authorization in writing to AGH (1307 Federal Street, Suite 500, Pittsburgh, PA 15212).

Parent, Guardian, or Athlete (if over 18) Signature (if guardian, give relationship and authority to act)	Date	Witness