Ochsner
Lafayette General
Sports Medicine

Authorization for Release of Medical Information and Consent for Treatment

Teurlings Catholic High School

Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated hereunder (collectively known as "HIPAA"), I authorize health care providers of

PATIENT NAME	DATE OF BIRTH

to disclose medical information regarding the injury and treatment of named individual to the following representatives of Teurlings Catholic High School: Athletic Director, Athletic Trainer, Supervising Team Physician, Team Coach, and Administrative Assistant to the Athletic Director for the purposes of treatment, emergency care and injury record-keeping.

Medical Information, in this context, pertains only to patient health care records regarding a specific injury and the treatment thereof. The request for medical information includes all patient health care records regarding the care, evaluation, prognosis, referral or treatment including, but not limited to, any and all records, reports, correspondence, radiographic films pertaining to the care and treatment of an injury sustained by the above-named student-athlete on. This includes all portions of my medical records which my physicians, or other health care providers, or I have specifically designated as "confidential." I understand that my signed authorization will be kept in a locked cabinet along with all medical information received and that said information will be available only to the individuals named above.

Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining patient's authorization. The purpose of disclosure of medical records is to facilitate treatment of injured student-athletes. I understand that the information obtained by the use of this authorization may be subject to re-disclosure and the information obtained is therefore no longer protected by HIPAA. This consent is revocable by the patient at any time except to the extent that the provider listed above has taken action upon it. A revocation is effective by the Health Care Provider listed above upon receipt of a written request to revoke, and a copy of the executed authorization form. A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain in effect for one year from date of signing. The athlete and parent must sign below before the athlete is allowed to play.

This authorization specifically authorizes the health care provider to disclose records created at any time after the signing, regarding the specific injury, until the authorization expires one year from the date of signing

Due to a contract with OLG Sports Medicine to provide a Licensed Athletic Trainer to work with Teurlings Catholic High School student-athletes, I hereby authorize that individuals from these programs, involved in the care and treatment of the above-named individual, also have access to the records. Therefore, I give permission for the licensed athletic trainer to release information concerning my child's injuries to the head coach, assistant coach, athletic director/principal of his or her school. I also give permission to the athletic trainer to receive health information concerning my child's injuries from any hospital, imaging center or treating/consulting physician. I understand that a confidentiality agreement, pertaining to any medical information released to them, will be signed by the individuals named in this paragraph and kept on file at Teurlings Catholic High School.

Parent or Legal Guardian please read the following:

- I hereby give my permission to undergo medical treatment for any injury or illness that may be sustained or acquired during high school athletics by a licensed athletic trainer with ______________________ (school name) and Ochsner Lafayette General Sports Medicine.
- I understand that the licensed athletic trainer will perform only those procedures that are within their training, credentials, and scope of professional practice to prevent, care for, and rehabilitate athletic injuries.
- I understand that if my son/daughter suffers a potentially life-threatening injury or illness, and in the event that we [parent(s)/ guardian(s)] cannot be reached within a reasonable period of time, that I authorize any duly licensed medical practitioner to perform such procedures as may be medically necessary to alleviate the problem.

ATHLETE'S (PATIENT'S) SIGNATURE	PRINT ATHLETE'S NAME	DATE
PARENT/GUARDIAN'S SIGNATURE	PRINT PARENT/GUARDIAN'S NAME	DATE