

**PART III -AUTHORIZATION/CONSENT FOR  
DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby authorized the athletic trainers, sports medicine staff and other health care personnel representing \_\_\_\_\_, to release information regarding the Student Athlete's protected health information and related information regarding any injury or illness during the Student Athlete's training for and participation in interscholastic sports at \_\_\_\_\_ School. This protected health information may concern the Student Athlete's medical status, medical conditions, injuries, prognosis, diagnosis, athlete's participation status, and related personally identifiable health information. This protected health information may be released to other health care providers, hospitals and/or medical clinics and laboratories, Student Athlete's coaches, medical insurance coordinators, the school's Athletic Director and Principal, athletic and/or school administrators, chaplains and/or clergy members, and officials of the Florida High School Activities Association. I also authorize the Student Athlete's coaches and other school staff to release protected health information to the athletic trainers, sports medicine staff and other health care personnel as identified above and to other health care professionals providing services to the Student Athlete.

As the parent or guardian of the Student Athlete, I hereby confirm that I have signed this authorization/consent for the disclosure of the Student Athlete's protected health information voluntarily. I understand that my child's protected health information is protected by federal regulations under the Health Information Portability and Accountability Act (HIPAA) of the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either parent/legal guardian authorization under HIPAA or consent under the Buckley Amendment. I the parent/legal guardian understand that once protected health information is disclosed per authorization or consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I, the parent/legal guardian, understand that I may revoke this authorization/consent at any time by notifying in writing to the school's Athletic Director, but if I do, it will not have any effect on the actions the Okaloosa County School officials took in reliance on this authorization/consent prior to receiving the revocation. I understand that I may see and obtain a copy of all protected health information described on this form, for a reasonable copy fee, if I ask for it. I further understand that I may request a copy of this form after I sign it. This authorization/consent expires one year from the date it is signed.

**I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE AND RELEASE OF THE STUDENT ATHLETE'S PROTECTED HEALTH INFORMATION AS STATED.**

\*\*\*\*\*

**BY SIGNING BELOW I VERIFY THAT I HAVE READ, REVIEWED AND COMPLETED ALL THREE (3) PARTS OF THIS PERMISSION AND AUTHORIZATION FORM.**

\_\_\_\_\_ Date \_\_\_\_\_ Signature of Parent or Guardian

<b>STATE OF FLORIDA - COUNTY OF OKALOOSA</b>	
The foregoing instrument was acknowledged before me this _____ by _____	
Date	Name of Person Acknowledged
who is personally known to me or who has produced _____ as identification and who did/did not take an oath.	
Type of identification	
_____ Signature of Notary Taking Acknowledgment	_____ Name of Notary (Typed, Printed or Stamped ) Notary Expiration: _____

School: \_\_\_\_\_

MIS 4178  
REV 7/03

**SCHOOL DISTRICT OF OKALOOSA COUNTY  
INTERSCHOLASTIC ATHLETICS PARENTAL PERMISSION,  
EMERGENCY MEDICAL AUTHORIZATION AND AUTHORIZATION TO RELEASE INFORMATION**

*No student will be allowed to practice or participate in any organized interscholastic athletic activity until this document is signed, notarized and returned to the school Athletic Department.*

Student Name \_\_\_\_\_ Grade \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
\_\_\_\_\_ Emergency Phone \_\_\_\_\_

**PURPOSE:** To provide the consent of parents and/or guardians for students to participate in interscholastic activities of the School District and to authorize the provision of emergency medical treatment for that student who may become ill or injured during such activities and authorizing the release of protected health information. PLEASE COMPLETE PARTS I, II AND III.

**PART I—PARENTAL PERMISSION**

I, \_\_\_\_\_ hereby grant permission for \_\_\_\_\_ (the "Student Athlete") to participate in interscholastic athletics during the school year and hereby release and agree to hold harmless the School District of Okaloosa County, its officers, agents and employees,

\_\_\_\_\_ School and its Athletic Department from all liability arising out of injuries sustained by \_\_\_\_\_ while participating in interscholastic sports activities or practices. I understand the Florida High School Activities Association requires all students participating in interscholastic athletics be covered by a medical

insurance policy providing a minimum of \$25,000 limit for medical expenses. I hereby certify \_\_\_\_\_ is covered by medical insurance

providing at least \$25,000 for medical expenses. The name of our medical insurance company is \_\_\_\_\_ which will cover this child in the event of an injury. I assume full responsibility and liability for any and all expenses connected with an injury and/or illness that is not paid by our insurance company or through Military benefits if this child is entitled to military privileges. I further certify I will notify the principal of the school this child is attending if there is any change in this insurance coverage, and I will purchase the Student and/or Football Insurance offered at the school.

I also hereby consent to allow \_\_\_\_\_ to be transported by private automobile in connection with \_\_\_\_\_

For the inclusive dates of: \_\_\_\_\_.

**STUDENT AND/OR FOOTBALL INSURANCE MAY BE PURCHASED AT YOUR SCHOOL**  
*Athletes, other than High School football participants, can be covered by purchasing the "school time" or "24 hour coverage".*

**PART II- EMERGENCY MEDICAL AUTHORIZATION**

In the event reasonable attempts to contact me at \_\_\_\_\_ (Phone number) have been unsuccessful, I give my consent for (1) the administration of any treatment deemed necessary by \_\_\_\_\_ (Preferred physician) or \_\_\_\_\_ (Preferred dentist), or in the event

the designated preferred practitioner is not available, by another physician or dentist and (2) the transfer and admission of the child to \_\_\_\_\_ (Preferred hospital) or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist concurring in the necessity for such surgery are obtained prior to the performance of such surgery. I hereby authorize any treating physicians, including athletic trainers and team volunteer doctors, to provide information to school officials regarding my child's medical condition or injuries.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: \_\_\_\_\_

**MEDICAL PROVIDERS MAY ACCEPT A PHOTOCOPY OF THIS SIGNED AUTHORIZATION AS IF IT WERE AN ORIGINAL FOR ALL PURPOSES.**

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION ON REVERSE SIDE**  
(OVER)