#10 Doctors Park • Gibson City, IL 60936 • (217)784-2650 • Fax (217) 784-8023
227 Market St • Paxton, IL 60957 • (217) 379-2500 • Fax (217) 379-2554
Sports Medicine · Stronger Everyday

RELEASE OF INFORMATION FOR THERAPY SERVICES AND SPORTS MEDICINE

I hereby authorize Gibson Area Hospital Therapy Services and Sports Medicine to disclose information related to sports injury and/or physical rehabilitation from the health records of:

Athlete's Name:_____ Date of Birth: _____
Last First Middle Initial (Mo/Day/Yr)

Address: _____ City: _____ Zip Code: _____

Home Phone:___(_____)_____ Emergency phone:_____(_____)_____

Emergency Contact Name: _____ Name of School: _____

THIS INFORMATION MAY BE DISCLOSED TO THE COACHES, SCHOOL ADMINISTRATIVE STAFF, AND MEDICAL PROVIDERS INVOLVED IN THE TREATMENT OF ATHLETIC INJURIES FOR THE PURPOSE OF COORDINATING SPORTS PARTICIPATION, REHABILITATION, AND PROGNOSIS OF RECOVERY FROM A SPORTS INJURY.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Gibson Area Hospital Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the end of each school year.
The current school year is:

20_____ To **20_____**

If I fail to specify a school year, this authorization will expire in six months after the date the form was signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need to sign this form in order to enable communication between my child's coach (es) and athletic trainer. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal law confidentiality rules. If I have questions about disclosure of my health information, I can contact Candy Underwood, Chief Privacy Officer / Health Information Services Director at Gibson Area Hospital and Health Services, 217-784-2712.

□ I **DO AUTHORIZE** G.A.H. Sports Medicine to disclose medical information to coaches, school administration, and medical providers involved in the treatment of an athletic injury.

□ Please **DO NOT DISCLOSE** medical information to any coaches or staff.

SIGNED: _____ DATE:_____
STUDENT ATHLETE (signature optional unless over 18 years old)

SIGNED: _____ DATE:_____
PARENT / GUARDIAN (signature is mandatory for communication to occur)