Northeast Georgia
PHYSICIANS GROUP

Authorization to Disclose Health Information

Patient's Name: _____ Date of Birth: _____

I authorize Northeast Georgia Physicians Group Sports Medicine to use or disclose the above named individual's health information as described below, concerning the period from 1/07/2017 to 5/31/2018.

Medical information, as specified:

X Other (specify): **Pre-Participation Exam and any subsequent athletic injury**

This information may be disclosed to and used by the following individual or organization:

Name: Athletic Department and School Administration at Gainesville City School District
Address: 508 Oak St Ste 2
Gainesville, GA 30501

Name: Gainesville City School District
Address: 508 Oak St Ste 2
Gainesville, GA 30501

Purpose: To assist the coaches, school administration and Gainesville City School District with the athlete's ability to participate in athletics

Special Instructions: Only coaches from the particular sport or Athletics Director, School Administration and Gainesville City School District may receive this information.

I understand that I have a 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 health information management 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 on the following date, event, or condition: **5/31/2018**. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. 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 confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information Management Services at (706) 721-2722.

My participation in this physical also grants NGPG permission to use my name and photographic likeness in all forms and media for advertising, exposition displays, trade and for any other lawful purpose.

_____ _____
Student Signature Date

_____ _____
Parent or Legal Representative Signature Date

_____ _____
If signed by Legal Representative, Relationship to Athlete Signature of Witness