Northeast Georgia
PHYSICIANS GROUP

Authorization to Disclose Health Information

Patient's Name: _____ Date of Birth: _____

I understand that by signing this form, I authorize Northeast Georgia Physicians Group, Sports Medicine to provide or disclose the above named individual's sports pre-participation examination as described below, concerning the period from 4/01/2018 to 5/31/2019.

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 Jefferson City School District
Address: 575 Washington Street
Jefferson, GA 30549

Name: Jefferson City School District
Address: 575 Washington Street
Jefferson, GA 30549

Purpose: To assist the coaches, school administration and Jefferson 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 Jefferson 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: **5/31/2019**. 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. 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