



**NovaCare™**

**REHABILITATION**

*a Select Medical company*

SPORT

GRADE

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

**Student Athlete Name:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**By signing this authorization, I authorize NovaCare Rehabilitation and their designated <Licensed / Certified> Athletic Trainer(s) assigned to Butler School District to act in the capacity of an approved medical provider to use and disclose the above persons' health information to appropriate medical professionals, coaches, assistant coaches and other athletic staff as reasonable and necessary in order to further this individual's injury care so that they may make decisions regarding their athletic ability and suitability to compete while participating as a student-athlete.**

I understand that if the individual(s) to which this information is released are not health care providers, health plans or health care clearinghouses subject to the federal Health Insurance Portability and Accountability Act (HIPAA) privacy rules, the health information disclosed pursuant to this authorization may be re-disclosed by such individuals without obtaining my authorization.

I further understand that I have the right to revoke this authorization at any time and that the revocation must be in writing and directed to NovaCare Rehabilitation. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that have already been made in reliance upon this authorization. This authorization will remain in effect until one calendar year past the date of my signature.

I have had the opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

\_\_\_\_\_

\_\_\_\_\_

**If signed by a Personal Representative, complete the following:**

Name of Personal Representative (please print): \_\_\_\_\_

Relationship to Participant or Nature of Authority (e.g. Guardian, Parent, Power of Attorney): \_\_\_\_\_

Phone Number of where you can be contacted: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_