Northwestern Medicine®

AUTHORIZATION TO RELEASE INFORMATION
ATHLETIC TRAINING SERVICES

Print Student-Athlete's Name_____

Date of Birth (DD/MM/YY) _____/_____/_____

I authorize Northwestern Memorial HealthCare ("NMHC") and its clinical affiliates to share my protected health information including but not limited to, relevant treatment information and test results, to the coaching staff and other individuals responsible for athletics at my School for purposes of my participation in athletics.

If I do not sign this authorization, NMHC clinical affiliates may not deny me care based on my unwillingness to sign this form.

I have the right to withdraw this authorization at any time. My withdrawal must be in writing. Any withdrawal will be valid except for the release of information that occurred prior to this authorization being withdrawn. For information on how to withdraw this authorization, contact the NMHC Health Information Department at 877-973-2673 or in writing to HIM Release of Information Department, 25 North Winfield Road, Winfield, Illinois 60190.

I understand that once the organization or person authorized to receive this information has received it, the information may be able to be re-released by that organization or person. If this is the case, the information may no longer be protected by federal privacy laws.

If not withdrawn, this authorization is valid for a period of four (4) years from the date of signature.

_____ _____

Signature of Parent / Legal Guardian Date Signed