MEDICAL AUTHORIZATION AND RELEASE OF HEALTH INFORMATION

As (please specify) self/parent/guardian of _____ ("the Athlete"), a participant of the Organization (NKYVC) in Kentucky, who is participating in programs of the Organization, I understand that in the course of competing in the Organization's Programs or Program-sponsored events the Athlete may require attention or assistance from an Athletic Trainer for illness or injury incurred while participating in such Program-sponsored events. I understand that the Organization has arranged for an Athletic Trainer or qualified medical provider from St. Elizabeth Healthcare to provide such attention and assistance during certain Program-sponsored events. I, the undersigned, hereby authorize St. Elizabeth Healthcare to treat and release all medical information about the Athlete obtained in the course of providing athletic training attention or assistance during Program-sponsored events to the Program's designated representatives including coaches, for the purpose of making determinations regarding the continued participation of the Athlete in the Program or Program-sponsored sporting events.

I understand that I have the right to revoke this authorization at any time except to the extent St. Elizabeth Healthcare has already acted as a result of this authorization. I further understand that any revocation must be provided in writing to St. Elizabeth Healthcare.

I also understand that when information is used or disclosed based on an authorization, the information may be re-disclosed by the recipient and no longer protected by the Standards for the Privacy of Individually Identifiable Health Information.

This authorization shall automatically expire one (1) year from the date of my signature below, or at termination of my relationship with NKYVC. I understand that I have the right to refuse to sign this authorization.

_____ _____
Athlete Name Street/Box Number

_____ _____
Athlete Date of Birth City, State, Zip Code

_____ _____
Athlete Signature Athlete Telephone Number
(required if 18 or over or will turn 18
before authorization expiration date)

_____ _____
Name of Parent or Guardian Date

_____
Signature of Parent or Guardian

_____
Relationship to Athlete (Parent, Guardian)

Notice of Privacy
I have received a copy of the St. Elizabeth Healthcare Notice of Privacy Practices (2013-Version):

Signature _____ Relationship (if not Athlete) _____