AUTHORIZATION FOR ACCESS, USE, OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, an athlete with the Asheville City Soccer Club (the "Club");
I, _____, the parent/legal guardian of _____, an athlete with the Asheville City Soccer Club (the "Club") (for student athletes under the age of 18 years)
Whose date of birth is _____, authorize MH Mission Hospital, LLLP by its general partner, MH Master, LLC ("MH"), and Asheville City Soccer Club (the "Club"), consent to and authorize the release by Mission of information about my medical condition obtained through the Sports Medicine Program to the Club's named coaches and other employees or agents of the Club. I also specifically consent to and authorize the sharing of my medical information among the Mission Sports Medicine staff (team physicians, other medical staff/providers, athletic trainers, and any student assistants) and the Club's athletic staff, coaches, and Club administration.

My signature below indicates that I understand and agree to the following:

1. This authorization for the release of my health information is voluntary, which means I do not have to authorize this release or sign this form.
2. As applicable, this release may include information related to behavioral/mental health, drug and alcohol abuse treatment, genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
3. My decision to sign this authorization will not have an effect on the treatment provided to me or my child by any applicable health care provider, the cost of that treatment, or any benefits.
4. I may revoke this authorization at any time by notifying Mission in writing.
5. Revoking this authorization will not affect any disclosures made prior to revoking this authorization.
6. Unless revoked or an **expiration date** is indicated here _____, this authorization will extend until the end of the 2021 Club season.
7. After release my information may no longer be protected by privacy regulations, which means the person receiving may be able to share that information without my permission.
8. Mission will not use or share my health information without my permission, except as allowed or required by law.
9. This form will not be used for marketing or research.
10. A fee may be charged for providing any requested medical records.
11. I may ask for and get a copy of this authorization. A readable photocopy/fax of this authorization shall have the same force and effect as the original.

I hereby authorize the access, use or disclosure of my or my child's health information as described in this form.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE TO THE TERMS AND CONDITIONS CONTAINED HEREIN. I HEREBY CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF THE CHILD NAMED HEREIN.

If athlete is a minor

_____
Name of Parent/Legal Guardian (Please Print)

_____
Signature of Parent/Legal Guardian

Relationship to Athlete_____

Date of Signature:_____

If athlete is 18 years of age and older

_____
Name of Athlete (Please Print)

_____
Signature of Athlete

Date of Signature:_____