Cass Health

Authorization for Release of Health Information - Minor

Student's Name _____

D.O.B. _____ /_____ /_____ Address _____

Phone _____

I hereby authorize Cass Health (including Cass County Memorial Hospital and Cass County Medical Clinics) (collectively, the "Hospital") to disclose to Atlantic Community School District athletic coaches and/or other School District officials my child's protected health information created or obtained by the Hospital in the course of conducting athletic training services. This disclosure is made at my request.

The Hospital may disclose any and all information which it has created or obtained regarding my care through the athletic training services.

I understand and acknowledge that:

1. I can revoke this Authorization at any time by giving my written revocation to the Hospital at the following address: Cass Health, 1501 East 10th Street, Atlantic, Iowa, 50022. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this Authorization.
2. The Hospital may NOT condition treatment, enrollment, or eligibility for benefits on whether I sign this Authorization.
3. I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law.
4. This Authorization is effective for five (5) years from the date on which it is signed.

A photocopy or exact reproduction of this signed Authorization shall have the same force and effect as the original.

_____ _____

Printed Parent/Guardian Name Date

_____

Signature of Parent/Guardian