

Cleveland Mustangs Authorization Form

I hereby authorize the release and disclosure of the personal health information of _____ ("Athlete"), as described below, to Cleveland Mustangs Track and Field Club ("Team").

The information described below may be released to the coach, athletic trainer, or other member of the team's administrative staff as necessary to evaluate the athlete's eligibility to participate in team activities.

Personal health information of the athlete which may be released and disclosed includes records of physical examinations performed to determine the athlete's eligibility to participate in team activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the team prior to determining eligibility of the athlete to participate in team activities; records of the evaluation, diagnosis and treatment of injuries which the athlete incurred while engaging in team activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the athlete's physical fitness to participate in team activities.

The personal health information described above may be released or disclosed to the team by the athlete's personal physician or physicians; a physician or other health care professional retained by the team's staff members to perform physical examinations to determine the athlete's eligibility to participate in certain team activities or to provide treatment to athletes injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the team; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the athlete while participating in team activities.

I understand that the team has requested this authorization to release or disclose the personal health information described above to make certain decisions about the athlete's health and ability to participate in team activities, and that the team is not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be re-disclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the team is covered under the federal regulations that govern the privacy of records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the athlete's participation in team activities may be conditioned on the signing of this

authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the team coach (or designee) whose name and address appears below.

Name of Coach:

Coach Address:

This authorization will expire when the athlete is no longer registered as an athlete of the team.

NOTE: IF THE ATHLETE IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE ATHLETE IS 18 YEARS OF AGE OR OVER, THE ATHLETE MUST SIGN THIS AUTHORIZATION PERSONALLY.

Athlete's Signature

Birth date of Athlete, including year

Name of Athlete's personal representative, if applicable

I am the Athlete's (check one):

_____ Parent _____ Legal Guardian (documentation must be provided)

Signature of athlete's personal representative, if applicable

Date

A copy of this signed form has been provided to the athlete or his/her personal representative.

THE ATHLETE SHALL NOT BE CLEARED TO PARTICIPATE IN ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE TEAM.