AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
CONSENT FOR TREATMENT: General Sports Medicine Program (U18)

Name of Event: _____ ("the event") Location of Event: _____
Date of Event: _____
Minor's Name: _____ Date of Birth: _____

Please list all the Minor's Medication and Medical Conditions: _____
_____
_____
_____
_____

I, _____ the Parent or Guardian signing below, hereby authorize physicians, nurses, athletic trainers or any other healthcare provider (collectively "Providers") of Memorial Healthcare System ("MHS") to conduct routine medical, medical screenings, diagnostic or any other procedure deemed necessary in order for the above minor child ("Child") to participate in the event. In the event that an injury occurs to Child while participating in the event. I further authorize and give permission to Providers to render to my Child appropriate and necessary care at that time. If medical necessity exists beyond that which can be reasonably dealt with on location, I further authorize and give permission to Providers to arrange for professional medical transport to a medical facility. I understand that efforts will be made to contact the parent or guardian in the case of a medical emergency.

I understand the MHS has both employed and independent contractors who may participate in the Child's care and that these individuals are not always employees or agents of MHS. I also understand that MHS contracts with physicians and physician groups to provide services to patients and that they may be independent contractors and are not necessarily the agents or employees of MHS. I understand that MHS is not legally responsible for the acts and omissions of its independent contractors or these individuals that are not employees or agents of MHS. I acknowledge that no guarantees have been made to me regarding the results of any examination, care or treatment to be provided by an MHS employee, agent, or independent contractor.

I hereby authorize physicians, nurses, athletic trainers or any other Providers who are employees or independent contractors of MHS to examine and evaluate Child and to release the health information to the event coordinator and his/her employees, coaches, and agents, for the purpose of engaging in the event and determining Child's ability to participate in the event. The health information consists of history, physical, examinations, medical screenings, past or present health information or information pertaining to injury or illness that may have a bearing on Child's ability to participate in the event. I also understand that the health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by Federal confidentially laws or MHS.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign and MHS will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that I may revoke this authorization at any time by notifying, in writing, the MHS representative at the event. In the event I revoke this authorization, it will not have any effect on actions taken by MHS prior to the revocation. This authorization will be effective until revoked or until the Child reaches eighteen (18) years of age.

PARENT(S) / GUARDIAN(S)

By: _____ _____ _____
Printed Name: _____ Date Signed Relationship to Child

By: _____ _____ _____
Printed Name: _____ Date Signed Relationship to Child