AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
UNIVERSITY SCHOOL CONCUSSION SCREENING AND MANAGEMENT

_____ _____
Printed Name of Student Date of Birth

_____ _____
Street Address City, State, Zip

AUTHORIZES THE RELEASE OF PROTECTED HEALTH INFORMATION:
By signing this Authorization Form, I understand that I am giving my authorization for East Tennessee State University to disclose my protected health information (PHI), as described in detail below, to the following person(s) or organization(s):

University School
68 Martha Culp Ave, Johnson City, TN 37614

I understand that if the person(s) and/or organization(s) listed above are not healthcare providers, health plans or healthcare clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

INFORMATION TO BE RELEASED:
I authorize my entire record created in relation to concussion screening, management and education to be released to the above.

PURPOSE FOR DISCLOSURE: The purpose of this authorization is for the University School and their Athletics Program to obtain a concussion screening to establish a baseline of neurocognitive function for concussion management for student athletes participating in collision and contact sports.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. In order to inspect or obtain a copy I must contact the ETSU SLP Clinic Site Director. I understand that I do not have to sign this form. If I choose *not* to sign this form, I will *not* be eligible to undergo the concussion screening. I understand that if I agree to sign this authorization, I must be provided with a signed copy of the form I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the ETSU SLP Clinic Site Director. I am aware that my revocation will not be effective as to uses and/or disclosures of health information that the person(s) and/or organization(s) listed above already made in reference to this authorization prior to my written cancellation of the same.

EXPIRATION DATE: This authorization shall expire upon Student's graduation date.

I have had an opportunity to review and understand the content of this Authorization Form. By signing below, I am confirming that this form accurately reflects my wishes.

_____ _____
Printed Name of Parent or Legal Guardian Date

_____
Signature of Parent or Legal Guardian