

**The Hughston Foundation, Inc. & The Hughston Clinic, P.C.**

Authorization to Release Medical Information

I, \_\_\_\_\_, being the parent/legal guardian of \_\_\_\_\_ and residing at \_\_\_\_\_, do hereby authorize

and consent to having The Hughston Foundation, Inc.'s and/or The Hughston Clinic, P.C.'s athletic trainers and/or consulting physician(s) provide any requested medical information to other physicians, other healthcare providers, the high school coaches or school administration, intercollegiate teams, professional teams, their scouts, recruiters, or athletic trainers which directly pertains to such child's or ward's (collectively "child") athletic participation at \_\_\_\_\_. Said Authorization To Release Medical Information will include, but is not necessarily limited to information concerning illnesses, injuries, treatments, hospitalizations, examinations, X-rays, or other forms of diagnostic testing occurring while participating in competitive athletics at said school or athletic organization, or otherwise medically related to such child.

I understand that I may revoke this Authorization by providing written notice to The Hughston Foundation, Inc., a Georgia nonprofit corporation. I also understand that if information has been released by relying upon this Authorization, that revocation will not be valid. I understand that injury treatment will not be conditioned upon signing this Authorization. I also understand that I am waiving my right to privacy with regard to the medical records and patient identifiable information by authorizing the release of my information.

I understand that the release of the medical information provided for herein is being carried out with my consent as the parent or legal guardian of such child, and accordingly, I assume full responsibility for any action taken in reliance upon this Authorization.

**I UNDERSTAND THAT SUCH CHILD'S MEDICAL INFORMATION IS CONFIDENTIAL AND PROTECTED BY A PHYSICIAN-PATIENT PRIVILEGE AND THAT I, AS THE PARENT OR LEGAL GUARDIAN OF SUCH CHILD, AM WAIVING THE PHYSICIAN-PATIENT PRIVILEGE TO THE FULL EXTENT PROVIDED FOR HEREIN AND AS ALLOWED BY LAW.**

\_\_\_\_\_  
**Signature of Parent/Legal Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Parent/Legal Guardian**

\_\_\_\_\_  
**Signature of Student Athlete**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Student Athlete**