PLEASE READ THE FOLLOWING FORM CAREFULLY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR ATHLETES PARTICIPATING IN WAKE COUNTY PUBLIC SCHOOL SYSTEM ATHLETICS

Once properly signed, this Authorization will allow for the release of protected health information to the Wake County Public School System ("WCPSS") by physicians and health care providers ("providers") rendering services to WCPSS athletes. The purpose of the release of the protected health information is to allow the WCPSS to determine the advisability of an athlete's participation in WCPSS athletics. An example would be the release of a screening physical examination.

By signing this Authorization for my son, daughter, or other person for whom I have the legal authority to act (hereinafter referred to as "Athlete"), I hereby authorize health care providers (including, but not limited to, the Duke University Sports Medicine Program and its physicians and providers) that are contracted with the WCPSS to release to each other and to the WCPSS oral and written medical information relating to the Athlete's medical or physical condition, illness or injury that may have a bearing upon past, present, or future participation in athletics of the WCPSS. The medical information should be used by the WCPSS for the purpose of determining the advisability of the Athlete's participation in WCPSS athletics.

This Authorization is expressly bound by all the following conditions:

i. This Authorization will automatically expire upon the Athlete's termination of participation or ineligibility in WCPSS Athletics, except to the extent relied upon for disclosures made prior to the automatic expiration.
ii. This Authorization may be revoked at any time, provided the **revocation is a properly executed written document and delivered to the Director of Athletics for WCPSS**. As soon as practicable, the WCPSS shall inform each contracted health care provider of each Athlete's revocation. However, any such revocation shall not affect disclosures made by a health care provider prior to that health care provider's receipt of the revocation from the WCPSS. In addition, such revocation shall not affect disclosures made prior to the receipt of the revocation to the extent that this Authorization was relied upon for such disclosures.
iii. This Authorization is not intended to alter the Athlete's ability to receive medical care from any health care provider regardless of whether this Authorization is agreed to or refused.
iv. This Authorization shall cover actions by and for Duke University, Duke University Health System, Inc. and the Private Diagnostic Clinic, PLLC, and all of their respective employees, workforce, and business associates, and all other physicians and health care providers contracted with WCPSS and their respective employees, workforce, and business associates. For a complete list of contracted health care providers of the WCPSS that may release medical information pursuant to the Authorization, please contact the WCPSS.
v. The athlete and Parent / Guardian will receive a complete copy of the signed Authorization.
vi. A copy of this Authorization and any revocation of it will be kept by both the Duke Sports Medicine Office, the WCPSS, and other health care providers contracted with the WCPSS.
vii. Protected health information released by the health care providers to the WCPSS is not protected by this Authorization from re-disclosure by the WCPSS

DATE: _____

_____
PARENT / GUARDIAN* (signed)

_____/_____
(Printed Name) / (Relationship to Athlete)

_____
Athlete's Name (Printed)

*This Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the Athlete's behalf**. By signing this form, you as the parent, guardian, or a party acting in loco parentis warrant that you have the legal authority to act on the Athlete's behalf.**

*The signature may be only the Athlete if the Athlete is over 18 years of age or a legally emancipated person.