

# Colorado Basketball Club



## MEDICAL RELEASE FORM

As the parent/legal guardian of \_\_\_\_\_, I request that in my absence the above-named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player. It is understood and agreed that I hereby assume liability for any and all medical expenses incurred as a result of my child's participation in Colorado Basketball Club events, including but not limited to ambulance transport, hospital stays, physician and pharmaceutical goods and services. Through the attached Authorization for Use or Disclosure of Protected Health Information, attached hereto as Exhibit A, I grant Colorado Basketball Club access to my child's medical records and protected health information as necessary to secure appropriate treatment for my child in my absence as necessary.

**Date of Players Birth** \_\_\_\_\_  
Month / Day / Year

**Date of last Tetanus Booster** \_\_\_\_\_  
Month / Day / Year

**Insurance Carrier** \_\_\_\_\_

**Policy Number** \_\_\_\_\_

**Group Number** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**Known allergies of this player, including any allergies to medicine** \_\_\_\_\_

**Any other medical problems which should be noted** \_\_\_\_\_

**Family Physician** \_\_\_\_\_

**Phone ( )** \_\_\_\_\_

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

**Address** \_\_\_\_\_

**City/State/Zip** \_\_\_\_\_

**Phone H( ) W( ) Cell ( )** \_\_\_\_\_

**Person responsible for charges (if different from above)** \_\_\_\_\_

**Address** \_\_\_\_\_

**City/State/Zip** \_\_\_\_\_

**Phone H( ) W( ) Cell ( )** \_\_\_\_\_

**Person to notify if parent/guardian is unavailable** \_\_\_\_\_

**Phone H( ) W( ) Cell ( )** \_\_\_\_\_

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

**Date**

8/12/2010

**EXHIBIT A**

**AUTHORIZATION FOR USE OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

**TO:** Name      Any health plan, physician, health care professional, hospital, laboratory, pharmacy, medical facility, or other health care provider that is providing or has provided payment, treatment or services to the Basketball Player identified below.

(At the time you first provide specific payment, treatment or services to the Basketball Player, please complete the information below and provide a copy to the Coaches.)

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This person/entity may be referred to as a "covered entity" (and it is the one possessing the PHI)

**Identification of Person to Receive PHI; Authorization.** With respect to the Protected Health Information ("PHI") identified in this authorization, I, the undersigned, hereby authorize the above-referenced person or entity and all of its directors, officers, contractors, employees and affiliates:

- To use the PHI for the purpose(s) identified in this authorization, and/or
- To disclose the PHI to the following individual(s) or entity (the "Coaches):

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Telephone \_\_\_\_\_  
Relation to Me \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Telephone \_\_\_\_\_  
Relation to Me \_\_\_\_\_

**Individual Whose PHI Is Being Released By This Authorization.** This authorization is being made with respect to the PHI of the following individual (the "Basketball Player"):

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
SSN (last 4 digits) \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone \_\_\_\_\_

**Description of PHI to be Used or Disclosed.** This authorization applies to the following PHI. (Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date(s) and type(s) of information provided, level of detail to be released, origin of information, etc.)

This authorization is to allow the above-identified Coach(es) to receive any and all PHI necessary or desirable to direct and obtain appropriate medical care and make related decisions with respect to the above-referenced Basketball Player.

**Purpose for PHI.** This PHI is being used or disclosed for the following purposes:

To allow for the provision of medical treatment and services to the Basketball Player in the event such treatment and services are needed and the Basketball Player's parents or guardians are not physically present at the time such treatment and services are provided.

**Expiration of This Authorization.** This authorization shall remain in force and effect until the following specified date or event that is related to the individual or the purpose of the use or disclosure of PHI, at which time this authorization to use or disclose this PHI expires.

The Basketball Player's graduation from high school or termination of membership in Colorado Basketball Club, whichever first occurs.

**Information About The Person Filling Out This Request.** Please select one:

- I am the individual identified above and am making this request with respect to the use and disclosure of my PHI. (If the above-referenced individual is under the age of 18, her parent or guardian must check the box below and sign this Authorization).
- I am the duly authorized personal representative of the individual identified above. Below is information regarding my status as the individual's personal representative:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

Proof of Status: \_\_\_\_\_

(Please include a copy of any conservator/guardianship papers or other document evidencing your status as personal representative.)

***Please Read Carefully and Sign***

I understand that I have the right to revoke this authorization before its expiration at any time by sending written notification to the covered entity first identified above. I understand that any revocation will not be effective to the extent that the covered entity has relied on the use or disclosure of PHI.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

If the covered entity first identified above is an health plan, the covered entity will not condition my treatment, payment, enrollment in the health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure, except in the situation where the Plan requests this authorization solely for the health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations (see below).

- If this box is checked, the health plan is requesting this authorization for my PHI for solely for the health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations. I understand that my enrollment in the health plan is considered upon my providing this signed authorization.

I understand that I have the right to refuse to sign this authorization. By signing this document, I hereby certify that the information provided above is true and accurate.

\_\_\_\_\_  
Signature of Individual or Authorized Personal Representative

\_\_\_\_\_  
Date

**A COPY OF THIS AUTHORIZATION, ONCE FULLY COMPLETED,  
MUST BE GIVEN TO THE INDIVIDUAL SIGNING IT.**