Authorization Form
For Uses and Disclosures of Patient Protected Health Information

I hereby authorize Leaf Chiropractic & Wellness Center to release my child's protected health information. Protected health information may include:

i. Information concerning my child's medical status, medical condition, injuries, prognosis, diagnosis, and other related personally identifiable health information, including injury reports, test results, x-rays, progress reports and any other documentation regarding my child's health status.

Authorization is granted for release of my child's protected health information to:

- The coaches, assistant coaches, and other athletic staff so that they make decisions regarding my child's athletic ability and suitability to compete through out the season.
- My child's teammates so that they may be aware of limitations that he/she may be under.
- Applicable medical providers and consultants to Leaf Chiropractic for the purpose of evaluating, diagnosing, treating, rehabilitating injuries/illnesses and to make a determination of my child's status/eligibility for participation.

Printed Name of Athlete _____

Date of Birth_____

Printed name of Parent/Guardian: _____

Parent/Guardian Signature: _____

Today's Date: _____