

**APPALACHIAN ORTHOPAEDIC ASSOCIATES, P.C.  
SPECIFIC USE AND DISCLOSURE FORM**

I, \_\_\_\_\_, authorize the physicians or physician assistants of Appalachian Orthopaedic Associates, P.C. to discuss the protected health information of

Sports Player \_\_\_\_\_

Player Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Insofar as that information is relevant to the Player's ability to participate in a school sport or game.

This information may be discussed only with the athletic director, coaches or athletic trainer of Vance Middle School for purposes of determining if the Player can continue to play in the school sport or game and under what conditions.

This authorization expires in one year.

Since the athletic director, coaches and athletic trainer are not covered by federal privacy regulations, the information described above may be disclosed by them to other individuals or institutions and is no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign may result in the Player being unable to participate in the sport or game.

Finally you may revoke this authorization in writing at any time by sending written notification to the Privacy Officer at AOA, 4105 Ft. Henry Dr., Suite 300, Kingsport, TN 37663. Your notice will not apply to actions taken by AOA prior to the date we receive your written request to revoke authorization.

\_\_\_\_\_  
Signature of Patient or Patient's Parent      \_\_\_\_\_ Relationship to Patient      \_\_\_\_\_ Date