EBS Sports Health, LLC. w/ PYHA

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____, 20____

I. THE PATIENT. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

PYHA Athletes Name: _____

Date of Birth: _____, 20____

II. AUTHORIZATION.

I authorize **EBS Sports Health, LLC.** ("Authorized Party") to use or disclose the following:

☐ - My medical information ONLY related to: **PYHA Concussion Baseline Testing and Sports Medicine Services**

☐ - Other: _____.

Hereinafter known as the "Medical Records."

III. DISCLOSURE. The Authorized Party has my authorization to disclose Medical Records to:

☐ - Any party that is approved by the Authorized Party.

IV. PURPOSE. The reason for this authorization is:

☐ - General Purpose. At my request (general).

☐ - Other: _____

Authorized Signature:

Print name_____ Signature_____

Date_____ Contact Phone_____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____.