MATTHEW J. MORAHAN HEALTH ASSESSMENT CENTER FOR ATHLETES
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____DOB_____

ADDRESS:_____TELEPHONE: _____
I hereby authorize the Matthew J. Morahan Health Assessment Center for Athletes ("MJM Center"), and Barnabas Health to disclose the Patient's health information described below to:

PEDIATRICIAN_____

PATIENT'S TEAM and/or SCHOOL STAFF OR REPRESENTATIVE: Debra O'Brien (School Physician)/ Debra Rosen-Haight (School Nurse)/ Christina Emrich (ATC)

ADDRESS AND/OR FAX NUMBER OF RECIPIENT (REQUIRED)_____

The Health Information described below is being disclosed for the following purpose:
To assess the Patient's ability to participate in sports activities and for related team and school purposes.

Information to be disclosed:
Results of all Cardiac Screenings, all Baseline Concussion Screenings and all Post Injury Concussion Testing on the Patient named above, which screening and/or testing were performed by, or sent to the MJM Center, and/or performed by or sent to Barnabas Health, during any dates before or after this form is signed.

This authorization will expire **four (4) years from the date of my signature below**, unless I otherwise specify that this authorization will terminate on the following date:_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written revocation to the MJM Center Director. I understand that this revocation will not apply to the extent that Barnabas Health and the MJM Center have already released my information in reliance on this authorization.

I understand that this disclosure of my health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment, payment for treatment, enrollment or eligibility for health benefits, but I understand that in some cases, my school may not pay for tests performed by the MJM Center unless I release the results to the school. I understand that once my information has been disclosed to the school or team named above, health care provider privacy laws may no longer apply, and any disclosure of information carries with it the potential for an un-authorized re-disclosure by the recipient. If I have questions about the disclosure of my health information under this form, I can contact the MJM Center Director.

PATIENT SIGNATURE: _____ DATE:_____

If legal representative (e.g., parent or guardian of a minor), is signing below, please state relationship and authority to sign on behalf of patient.

SIGNATURE OF LEGAL REPRESENTATIVE/PARENT/GUARDIAN: _____

PRINT NAME OF LEGAL REPRESENTATIVE/PARENT/GUARDIAN:_____DATE:_____

RELATIONSHIP OF REPRESENTATIVE TO PATIENT: _____

PATIENT (OR REPRESENTATIVE OF MINORS) MUST BE GIVEN A COPY OF THE AUTHORIZATION FORM