I hereby request and authorize that Valley Medical Clinic release the health of the individual below, of whom I am a parent or guardian:

Print Student Name_________________________________DOB_________________

Phone___________________________

I authorize the health information of the above-named individual to be disclosed to and used by <u>Sedgwick County Athletics</u>, for the purpose of record retention and evaluation with respect to the participation and competition in athletic and extracurricular activities sponsored by the school.

The information to be disclosed is that pertaining to the physical conducted on _______________________. (Date of physical) 2024-2025 School Year

I understand that this authorization will expire, without my express revocation, one (1) year from the date of signing. I further understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. That is, I understand that my revocation will not apply to information that has already been released to the school as specified by this authorization.

I understand that authorization for the disclosure of this health information is voluntary and that I can refuse to sign this authorization.

I understand that any disclosure of information pursuant to this authorization carries with it the potential for re-disclosure by the school and that Federal Confidentiality Rules may not protect such information.

I understand that Valley Medical Clinic will keep this form and retain this copy of this authorization at Valley Medical Clinic at Julesburg, CO.

Print Parent/Guardian Name ____

Signature of Parent/Guardian_________________________________Date______________