

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

_____ (Physician)
_____ (Address)
_____ (City, State, Zip)

On behalf of my minor child, _____, whose Social Security number is _____, and whose date of birth is _____, I hereby authorize the above-identified physician to release to Rob Worley, chairman of the Louisiana Junior Tennis Council, 9270 Siegen Lane, Suite 702, Baton Rouge, Louisiana 70810, telephone (504) 491-6924, facsimile (504) 589-8192, all information you may have, without limitation, regarding my child's medical condition as revealed by your observation or treatment, past, present and future. This Authorization is for the purpose of determining the child's eligibility for a medical waiver excusing him/her from playing in the Louisiana Qualifying Junior Tennis Championship. The information to be released includes:

Diagnosis, including those relating to alcohol, drug, or substance abuse and/or mental health, if any;

Histories and physical examination reports;

Consultations;

Laboratory and x-ray reports;

Admitting and discharge summaries;

Operating room notes, records, and reports;

Physician and nurses notes;

Progress notes and reports;

Physician's orders;

Treatment plans;

Psychological, psychosocial, psychotherapy and social work assessments, notes, evaluations and/or consults;

Psychiatric assessments, evaluations and/or consults;

Patient information sheets; and

Billing and insurance information.

I understand that my child's records (including alcohol, drug or substance abuse, or mental health information) are protected by federal regulations. This Authorization (unless expressly revoked earlier in writing) expires upon completion of the release of information indicated to the party named in this Authorization. I may revoke this Authorization at any time prior to its expiration by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before receiving the Authorization. Any such revocation must be sent via U.S. mail, Federal Express, UPS, hand delivery, or facsimile. The above-identified health care provider and its representatives are hereby released from all legal liabilities that may arise from the release of information in reliance on this Authorization. This Authorization is for the production of records, and also written communications and verbal communications (in person or by telephone) between the physician and Mr. Worley regarding such patient information. Mr. Worley may share this disclosed medical information with members of the Louisiana Tennis Association Board of Directors and the Louisiana Junior Tennis Council. The information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected by federal regulations. I will be provided with a copy of this Authorization. I hereby agree that a photostatic copy of this Authorization may serve as an original.

SIGNATURE

ADDRESS (Please Print)

DATE

SIGNATURE OF WITNESS:

DATE