Waiver and Release of Information

By signing below, I hereby grant and assign designated individuals at **Kamloops Minor Hockey Association** the right to have access to and to use my child's medical information and records for purposes relating to injury assessment and treatment in connection with my child's status as a player for the **Kamloops Minor Hockey Association** team. I further authorize any individual who has records pertaining to the above-referenced injury assessment and treatment at **Kamloops Minor Hockey Association** to release such records, upon request, to **HeadCheck Health**. Furthermore, I authorize **Kamloops Minor Hockey Association** use or release such records to healthcare providers or other organizations that may assist them in meeting my child's healthcare needs.

I may revoke this authorization in writing at any time and that such revocation will be effective as of the date the written revocation is received by **Kamloops Minor Hockey Association**.

Privacy Notices:

The below named athlete, are entitled to certain privacy rights regarding protected health information according to the Personal Information Protection and Electronic Documents Act (PIPEDA). During the course of injury assessment and treatment, paper and/or electronic records describing your child's health history, symptoms upon examination and test results, diagnoses, treatment and any plans for future care or treatment will be collected. You understand that this information serves as:

- A basis for assessing your child's injuries, planning your child's care, and treatment;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of care providers.

You have the following rights and privileges:

- The right to review the notice prior to signing this consent;
- The right to request restrictions as to how your child's health information may be used or disclosed to carry out treatment or care.

We treat this information as confidential and recognize the importance of protecting that information. A complete copy of HeadCheck Health's Privacy Policy is available upon request.

I have read the above information and accept the terms of this consent.

Athlete Name (Printed)	Date
Parent/Guardian Name (Printed)	
Parent/Guardian Signature	Date