EXHIBIT B

PLEASE READ THE FOLLOWING FORM CAREFULLY
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
FOR ATHLETES PARTICIPATING IN DURHAM PUBLIC SCHOOLS ATHLETICS

Once properly signed, this Authorization will allow for the release of protected health information to Durham Public Schools ("DPS") by physicians and health care providers ("providers") rendering services to DPS athletes. The purpose of the release of the protected health information is to allow DPS to determine the advisability of an athlete's participation in DPS athletics. An example would be the release of a screening physical examination.

By signing this Authorization for my son, daughter, or other person for whom I have the legal authority to act (hereinafter referred to as "Athlete"), I hereby authorize health care providers including Duke University, Duke University Health System, Inc., the Private Diagnostic Clinic, PLLC and their respective physicians, providers, employees, and workforce to release to each other and to DPS oral and written medical information relating to the Athlete's medical or physical condition, illness or injury that may have a bearing upon past, present, or future participation in athletics of DPS. The medical information should be used by DPS for the purpose of determining the advisability of the Athlete's participation in DPS athletics.

This Authorization is expressly bound by all the following conditions:

i. This Authorization will automatically expire upon the Athlete's termination of participation or ineligibility in DPS athletics: except to the extent relied upon for disclosures made prior to the automatic expiration.

ii. This Authorization may be revoked at any time, provided the **revocation is a properly executed written document and delivered to the Director of Athletics for DPS.** As soon as practicable, DPS shall inform each contracted health care provider of each Athlete's revocation. However, any such revocation shall not affect disclosures made by a health care provider prior to that health care provider's receipt of the revocation from DPS. In addition, such revocation shall not affect disclosures made prior to the receipt of the revocation to the extent that this Authorization was relied upon for such disclosures.

iii. This Authorization is not intended to alter the Athlete's ability to receive medical care from any health care provider regardless of whether this Authorization is agreed to or refused.

iv. The athlete and Parent / Guardian will receive a complete copy of the signed Authorization.

v. A copy of this Authorization and any revocation of it will be kept by DPS.

vi. Protected health information released by the health care providers to DPS is not protected by this Authorization from re-disclosure by DPS.

DATE: _____

_____
PARENT / GUARDIAN* (signed)

_____/_____
(Printed Name) / (Relationship to Athlete)

_____
Athlete's Name (Printed)

*This Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the Athlete's behalf. **By signing this form, you as the parent, guardian, or a party acting in loco parentis warrant that you have the legal authority to act on the Athlete's behalf.** The signature may only be signed by the Athlete if the Athlete is over 18 years of age or a legally emancipated person.