AUTHORIZATION FOR USE AND DISCLOSURE OF RECORDS AND INFORMATION

Name: _____ D.O.B.: _____

Address: _____

1. Persons/Entities Authorized to Release and Disclose Information:

I hereby authorize and give my permission to the following persons and/or entities to release and disclose my medical records, medical information, and/or "protected health information" (as defined under the Health Insurance Portability and Accountability Act, as amended, and the regulations thereunder ("HIPAA")), altogether, my "PHI", in the manner described in this Authorization:

> Tennessee Football, Inc., d/b/a Tennessee Titans ("Club"), the National Football League ("NFL") and each of its member Clubs, as now existing or at any time in the future, the National Football League Drug Advisers and Medical Advisors, National Invitational Camp, Inc., National Football Scouting, Inc., the advisors to the National Football League's Policy and Program on Substances of Abuse, the advisors to the National Football League's Policy on Anabolic Steroids and Related Substances, the advisors to the National Football League's Prescription Drug Program and Protocol, any NFL Club medical staff members, team physicians, athletic training staff members, committees, panels, programs and boards commissioned by the NFL for player health and safety initiatives, Quintiles, Inc., or any successor entity engaged by the NFL to provide data-related analytics and other services (including services intended to support player health and safety initiatives), any outside or third-party physicians, physician groups, hospitals, clinics, laboratories, consulting physicians, specialists, pharmacies, and/or healthcare professionals engaged by the NFL or any NFL Club(s) in furtherance of the releasor's employment as an NFL

Player, including but not limited to providing medical care to the releasor or other services intended to support player health and safety initiatives, and any present and future electronic medical record vendors and/or prescription networks used by the NFL or any NFL Club(s), including, but not limited to, eClinicalWorks, Inc., and/or Infinitt, Inc., and their respective representatives, agents, and/or employees, officers, servants, staff members, and contractors of the foregoing.

2. Personal Health Information to Be Used and Disclosed:

I hereby authorize the following medical records and/or PHI to be used and disclosed as described in this Authorization to the Authorized Parties (defined below):

My entire health or medical record and/or PHI relating to any injury, sickness, disease, mental health condition, physical condition, medical history, medical or clinical status, diagnosis, treatment or prognosis from any source, including without limitation all written and/or electronic information or data, clinical notes, progress notes, discharge summaries, lab results, pathology reports, operative reports, consultations, physicals, physicians' records, athletic trainers' records, diagnoses, findings, treatments, history and prognoses, test results, laboratory reports, x-rays, MRI, and/or imaging results, outpatient notes, physical therapy records, occupational therapy records, prescriptions, and any and all other information pertaining to my past, present, or future medical condition, diagnosis, treatment, history, and prognosis. This Authorization expressly includes all records and PHI relating to any mental health treatment, therapy, and/or counseling, but expressly excludes psychotherapy notes.

3. Persons/Entities Authorized to Receive and Use:

I hereby authorize the following persons and/or entities to receive and use my medical records and/or PHI only for the purposes that are permitted under this Authorization. These persons and entities will be referred to as the "Authorized Parties":

RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054, SOUTHFIELD, MI, 48086-5054,
P:248-357-3330, F:248-357-3337

4. Purpose of the Disclosure:

This Authorization for Use and Disclosure of Records and Information is *only* for purposes relating to:

PRE-TRIAL DISCOVERY

5. Expiration Date: This Authorization will expire two (2) years from the date of signature below.

6. Photocopy: A photostatic copy of this Authorization shall be considered as effective and valid as the original.

7. Signature: By my signature below, I acknowledge that I have read this Authorization, understand my rights as described herein, understand that I am allowing medical and mental healthcare providers, and others set forth in Section 1 above, to disclose my PHI, and have had any questions answered to my satisfaction.

Signature:_____ Date: _____

NOTICE: You are entitled to a copy of this Authorization after you sign it. You have the right to revoke this Authorization any time by presenting a written request to the Club's Head Athletic Trainer or his or her designee, except to the extent that any Authorized Party has relied upon it. Revocation will not apply: 1) to information that has already been released in connection with this Authorization, 2) during a contestability period under applicable law, or 3) if the Authorization was obtained as a condition of obtaining insurance coverage. We may not condition treatment, payment, enrollment, or eligibility for benefits on your execution of this Authorization, except for the purpose of creating protected health information for disclosure to a third party on provision of Authorization. Information disclosed pursuant to this Authorization may be re-disclosed by the recipient(s) and no longer protected by certain federal or state privacy laws or regulations. Information disclosed

pursuant to this Authorization may include records created by a healthcare provider or mental healthcare provider other than the disclosing party, unless access to such PHI has been restricted as permitted under HIPAA or other federal or state law, or unless such provider has expressly prohibited such re-disclosure.