STUDENT ATHLETE AUTHORIZATION/CONSENT FORM
FOR DISCLOSURE OF PROTECTED HEALTH & MEDICAL INFORMATION (HIPAA)

I hereby authorize all members of _____'s Sports Medicine/Athletic Training Staff, Team
(Name of school)
Physicians or any other physicians or health care professional providing health care to me to disclose and release information, records and reports regarding my medical history, medical status, record of injury and/or surgery, prognosis, diagnosis, record of serious illness, rehabilitation and related personally identifiable health information to the following:

- The student athletic trainers and other students who are providing or participating in the provision of medicine health-care while I am a student-athlete.
- The coaches, assistant coaches and other athletic staff so that they may make decisions regarding my athletic ability and suitability to compete while I am a student-athlete.
- My teammates so that they may be aware of my limitations that I may be under while I am a student-athlete.
- The Iowa High School Athletic Association, National Collegiate Athletic Association and the _____ conference for the purpose of making determination regarding my eligibility status while I am a student-athlete.
- Applicable insurance providers for the purpose of processing insurance claims while I am a student-athlete.
- My parents/guardian and/or spouse for the purpose of assisting me in making health-care decisions while I am a student-athlete.
- Any person or entities who are authorized to receive Protected Health Information regarding me under the Standard Authorization to Use or Disclose Protected Health Information form which I and/or my personal representative signed and dated _____.

I understand that _____will not receive compensation for its use or disclosure of the information. I
(Name of school)
also understand that the persons or entities listed above will not be covered by the Buckley Amendment or HIPAA, and that these regulations will not apply to the persons or entities who use or disclose the information. I may inspect or copy any information used/disclosed under this authorization.

The information includes injuries or illnesses relevant to past, present, or future participation in athletics at the _____.
(Name of school)

I understand that my injury/illness information is protected by federal regulations under the Health Information Portability and Accountability Act (HIPAA) or the Family Education Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without my authorization/consent under HIPAA or the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary. The reason for this disclosure is to advise any of the above individuals of the nature, diagnosis, prognosis or other treatment concerning my medical condition and injuries/illnesses sustained while I am a student-athlete. I understand that not all of the entities receiving this information are health care providers or health plans covered by federal privacy regulations and that the information described above may be re-disclosed publicly.

This authorization is valid for one year. However, it may be revoked at any time by notification in writing to this office.

Printed Name of Student Athlete: _____
Patient Signature (if under 18 -- parent/guardian): _____
Date: _____ Date of Birth: _____
Witness: _____ Date: _____

If form is signed by a parent/guardian, please complete the information below:
Parent/Guardian: _____ Relationship to Individual: _____
Parent/Guardian's Address: _____
City: _____ State: _____ Zip: _____
Telephone Number: Home: _____ Cell: _____