

LAKE ERIE COLLEGE – VARSITY ATHLETICS
Authorization/Consent Form
For the Use and Disclosure of Student-Athlete Protected Health Information

Student Athlete's Name: _____

Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____

Sport(s): _____

I hereby authorize the physicians, athletic trainers, and sports medicine staff for Lake Erie College to release information regarding my protected health information (PHI) and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics. The PHI may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related health information. This PHI may be released to other health care providers, parents/guardians, hospitals and/or medical clinics and laboratories, athletic coaches, medical insurance coordinators, insurance carriers medical supply vendors and or service companies, academic counselors, athletic and/or university administrators, and NCAA Injury Surveillance System.

I understand that my authorization/consent for disclosure of my PHI is an important, but not required, factor of participation in intercollegiate athletics at Lake Erie College. I understand that my PHI is protected by federal regulation under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment.

I understand that I may revoke this authorization/consent at any time by sending written notification to the Head Athletic Trainer, but if I do, it will not have any effect on actions Lake Erie College took in reliance on this authorization/consent prior to receiving the revocation. If you choose not to consent to the release of PHI, I understand that general status information will need to be released to the sports medicine staff and coaches concerning your participation status.

This authorization/consent expires 380 days from the date it is signed.

You may refuse to sign this authorization/consent. Your refusal will not affect your ability to obtain treatment or participate in intercollegiate athletics.

 Student-Athlete Signature: _____ Date _____

 Signature of Parent/Guardian (if student-athlete is under 18) _____ Date _____