Oakland City University

Student -Athlete Authorization/Consent for Disclosure of Protected Health Information

I hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel representing Oakland City University to release information regarding my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information.

This protected health information may be released to other health care providers, parents/guardians, hospitals and/or medical clinics and laboratories, athletic coaches, strength and conditioning coaches, medical insurance coordinators, insurance carriers, medical supply vendors and/or service companies, academic counselors, athletic and/or university administrators, chaplains and/or clergy members, NCAA Injury Surveillance System, sports information staff and members of the media.

I understand that my authorization/consent for the disclosure of my protected health information is a condition for participation as an intercollegiate athlete for Oakland City University.

I understand that my protected health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or FERPA (Family Educational Rights and Privacy Act of 1974 or 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 FERPA (Buckley Amendment).

I understand that I may revoke this authorization/consent at any time by notifying in writing the Athletic Trainer at Oakland City University, but if I do, it will not have any effect on actions Oakland City University took in reliance on this authorization/consent prior to receiving the revocation. I have received a copy of the Notice of Privacy Practices and understand these practices. This authorization/consent expires six (6) years from the date it is signed.

_____

Name of Student Athlete (print or type) Signature of Student-Athlete Date

_____

Social Security Number of Student-Athlete Date of Birth of Student-Athlete

_____

Signature of Parent/Legal Guardian (if student-athlete is under 18 years of age) Date

OAKLAND CITY UNIVERSITY INTERCOLLEGIATE ATHLETICS

Name: _____Sport: _____Date:_____

ASSUMPTION OF RISK

BY ITS NATURE, PARTICIPATION IN INTERCOLLEGIATE ATHELTICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG TERM CATASTROPHIC, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN TO DEATH. Although serious injuries are not common in supervised intercollegiate athletic activities, it is possible only to minimize, not eliminate the risk. Participants can and have the responsibility to help reduce the chance of injury. STUDENT-ATHLETES MUST OBEY ALL SAFETY RULES, REPORT ALL ATHLETIC INJURIES TO THE LICENSED ATHLETIC TRAINERS, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT ALL EQUIPMENT DAILY.
By signing this form, you acknowledge that you have read and understand this warning.

Athlete Signature: _____ Date:_____

Parent/Guardian: _____ Date:_____

MEDICAL CONSENT

I hereby grant permission to Oakland City University team physicians and Licensed Athletic Training staff to provide medical care to myself in the event that I become injured while participating in intercollegiate athletics. I understand that any treatment, medical, or surgical care that is provided to me will be done only if it is considered medically necessary for my health and well being.

Athlete Signature: _____ Date:_____

Parent/Guardian: _____ Date:_____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize and request OCU licensed athletic trainers and / or their consulting physician (s) to furnish any and all requested information to their physicians, or athletic trainers, which directly pertains to my participation in athletics at OCU. Said authorization shall include, but is not limited to: information concerning my physical condition, illnesses, injuries, treatment, hospitalizations, examination, X-rays, or other forms of diagnostic testing. I hereby fully discharge all parties to whom this authorization extends from any and all penalties of breach of student-athlete confidentiality.

Athlete Signature: _____ Date:_____

Parent/Guardian: _____ Date:_____

MEDICAL REFERRAL PROCEDURE EXPLANATION

Any appointment made with specialists (orthopedist, podiatrist, etc.) will require a referral from the university sports medicine staff and maybe from your insurance carrier or primary care physician. It is your responsibility to acquire this referral. Participation in athletics at OCU is limited to athletes covered by their own medical insurance. OCU athletics only offers catastrophic and secondary accident insurance coverage to student-athletes.

Athlete Signature: _____ Date:_____

Parent/Guardian: _____ Date:_____

(05/2010)