

## 2019-2020 AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (HIPPA FORM)

I hereby request and authorize that Vernon College Athletic Training release the health information of the individual named below;

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City State Zip

I authorize the health information of the above-named individual to be disclosed to and used by Vernon College, for the purposes of record retention and evaluation with respect to participation and competition in athletic and extracurricular activities sponsored by Vernon College.

The following methods of communication and injury documentation can be used:

- Oral, written, or electronic communication regarding health issues between the athletic trainer, the team physician and supporting medical staff.
- Oral, written, or electronic communication regarding health issues between the athletic trainer, coaching staff and athletic director.
- Oral, written, or electronic communication regarding health issues between the athletic trainer, and the student-athletes parents, per athlete's request.
- Oral, written, or electronic communication regarding health issues between the athletic trainer, the team physician, supporting medical staff and the Insurance Company, Carrier, Program Administrator or Claims Administrator in which Vernon College purchased Secondary Student Basic Accident Medical on my behalf.

The information to be disclosed is that pertaining to any injury sustained during the 2018-2019 academic year.

I understand that this authorization will expire, without my express revocation, one (1) year from the date of signing. I further understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. That is, I understand that my revocation will not apply to information that has already been released to the School as specified by this authorization.

I understand that authorization for the disclosure of this health information is voluntary and that I can refuse to sign this authorization. Vernon College cannot condition treatment on the signing of this authorization, except as otherwise permitted by law.

I understand that any disclosure of information pursuant to this authorization carries with it the potential for re-disclosure by Vernon College and that such information may not be protected by federal confidentiality rules.

I understand that Vernon College must document and retain a copy of this authorization.

\_\_\_\_\_  
 SIGNATURE OF STUDENT-ATHLETE

\_\_\_\_\_  
 DATE

\*\* If student-athlete is still a minor then parent signature is needed.