



Authorization for Use, Disclosure, & Release of Health Information

Athletics

2500 E. Nutwood Ave.
Fullerton, CA 92831 USA
(714) 879-3901 x1214
kasponsel@hiu.edu

Student Athlete Print Name

Date of Birth

Address

City

State

Zip Code

Authorization for use and or disclosure of health information:

I authorize the following persons (or class of persons) to make authorized use and/or disclosure of my protected health information: Team physicians, consulting physicians, athletic trainers and assistants, physical therapists and assistants, HIU Sports medicine department personnel and support staff.

Release of Health information to:

I authorize the following persons (or class of persons) to receive my protected health information: Hope International University Athletic Director, Assistant athletic directors, coaches, athletic department staff, HIU athletic trainers and assistants, third parties for insurance and billing purposes, and other healthcare providers for diagnosis and/or treatment purposes.

Information that may be released:

- | | | |
|---|--|---|
| <input type="checkbox"/> Entire record | <input type="checkbox"/> Medical history, examination, reports | <input type="checkbox"/> Surgical records |
| <input type="checkbox"/> X ray reports | <input type="checkbox"/> Treatment and tests | <input type="checkbox"/> Prescriptions |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Hospital records including reports | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> Other _____ | |

Purpose for disclosure:

- | | | |
|--|--|---|
| <input type="checkbox"/> Further medical care | <input type="checkbox"/> Legal investigation or action | <input type="checkbox"/> Changing physicians |
| <input type="checkbox"/> Medical ability and fitness to participate in athletics | | <input type="checkbox"/> Health and injury Status for athletics |
| <input type="checkbox"/> Insurance eligibility/benefits | | |

I understand that if the persons and/or organizations listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization. However, redisclosure by school officials may be subject to student education records privacy laws.

Your rights with respect to this authorization:

- Right to inspect or copy the health information to be used or disclosed** – I understand that I have the right to inspect and copy the health information that I have authorized to be disclosed by this authorization form. I may arrange to inspect my information or make copies by contacting the Athletic Director.
- Right to receive a copy of this authorization** – I understand that if I agree to sign this form, which I am not required to do, I must be provided with a signed copy of the form
- Right to refuse to sign this authorization** – I understand that I am under no obligation to sign this form and that the persons and/or organizations listed above who I am authorizing to use and or disclose my information may not condition treatment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization
- Right to withdraw authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization, or obtain a copy of my withdrawal, I may contact the Athletic Director. I am aware that my withdrawal will not be effective as to uses or disclosures of my health information that have already been made by the persons and/or organizations listed above in reference to this authorization.

Expiration Date – this authorization is good for one year from the date signed.

Student/Athlete Signature

Date

Witness Signature

Witness Print Name