DELAWARE STATE UNIVERSITY
Sports Medicine Department

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STUDENT-ATHLETE AUTHORIZATION/CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby, authorize the physicians, certified athletic trainers, sports medicine staff and other health care personnel representing Delaware State 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, emergency room physicians and personnel, athletic directors, athletics coaches, strength and conditioning coaches, medical insurance coordinators, insurance carriers, academic counselors, athletic and/or college administrators, clergy members, NCAA Injury Surveillance System, sports information staff and members of the media.

I understand that my authorization/consent for the disclosures of my protected health information is a condition for participation as a student-athlete for Delaware State University. I understand that my personal health information is protected by federal regulations 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 notifying, in writing, the Head Athletic Trainer, but if I do, it will not have any effect on actions that Delaware State University took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent expires one year from the date of my signature below.

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Social Security Number Date of Birth

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Print Name of Student-Athlete Signature Date

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Print Name of Parent/Guardian (if under 18)

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Signature of Parent/Guardian (if under 18) Date