

DELAWARE STATE UNIVERSITY
Sports Medicine Department

1200 North DuPont Highway, Memorial Hall Gym, Dover, DE 19901 302-857-7552 Fax: 302-857-7312

**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.

Social Security Number

Date of Birth

Print Name of Student-Athlete

Signature

Date.

Print Name of Parent/Guardian (if under 18)

Signature of Parent/Guardian (if under 18)

Date

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Student-Athlete Authorization/Consent for Printing and Copying of Medical Documents

I hereby, authorize the certified athletic trainers, sports medicine staff and other health care personnel representing Delaware State University to print and copy medical documents paper or digital form for internal use of the Delaware State University Sports Medicine Department. This includes but is not limited to pre-participation physical exam forms, injury reports, emergency travel forms, and acknowledgement/consent forms.

Signature _____ Date _____

Signature of Parent/Guardian (if under 18): _____ Date: _____

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Sports Medicine Services (2017-2018)

NOTICE OF PRIVACY POLICIES FOR DELAWARE STATE UNIVERSITY SPORTS MEDICINE SERVICES.

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Delaware State University, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective 09/11/13, and applies to all protected health information as defined by federal regulations.

Understanding your health record/Information

Each time you visit the Sport Medical Services; a record of your visit is made. You will also receive treatments and consultation in the public Athletic Training Room where other student athletes may be present to witness evaluations, diagnosis, treatments and rehabilitation. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you receive.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- A tool in educating health professionals.
- A source of information for public health officials charged with improving the health of this state and the nation.
- A source for data planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

Although your health record is the physical property of Delaware State University's Sports Medicine Center, the information belongs to you. You have a right to:

- Obtain a paper copy of this notice of information practices on request.
- Inspect and receive a copy of your health record as provided for in 45 CFR 164.524.
- Amend your health record as provided in CFR 164.528.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
- Revoke your authorization to use or disclose your health information except to the extent that action has already been taken.

Our Responsibilities

Delaware State University's Sports Medicine Services is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect To information we collect and maintain about you.
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information By alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. In case of policy changes you may need to sign a new form. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information you may contact the practice’s Privacy Officer at 302-857-7551. If you believe your privacy rights have been violated, you can file a complaint with the practice’s Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for civil Rights. The Address for the OCR is: **Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, DC 20201.**

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your health care provider will document in your record his or her expectations. The members of your health care team will then record the actions they took and their observations. In that way, the healthcare provider will know how you are responding to treatment. We will also provide your healthcare provider with copies of various reports that should assist him or her in your treatment. This will include all health care providers in our practice and those assisting in coverage of our practice.

We will use your health information for payment.

For example: A bill may be sent to you or a third –party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we’ve asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. We may leave a message on your answering machine or voice mail as a means of communication.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that Person’s involvement in your care or payment related to your care.

Food and Drug administration (FDA): We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight, agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

I have read Delaware State University Private Policy for the Sports Medicine Services.

Signature: _____ **Date:** _____

Signature of Parent/Guardian (if under 18) _____ **Date:** _____