CINCINNATI BEARCATS SPORTS MEDICINE

Authorization for Release of Medical Information

Section A: Individual Authorizing Use and/or Disclosure of Protected Health Information. This authorization will be good for the duration of the five year eligibility status.

Last Name: _____ First Name: _____ MI: _____ M#:_____

Date of Birth:_____ Social Security Number:_____ Sport: _____

Section B: Access and Disclosure of Protected Health Information

The Protected Health Information will be injury and/or illness information that directly affects your participation in intercollegiate athletics. By giving permission to disclose Protected Health Information, you give permission to disclose any Protected Health Information to any of the parties indicated below within the discretion of the Assistant Athletic Director for Sports Medicine.

I hereby authorize the release of medical information to The University of Cincinnati Sports Medicine Department, including the Athletic Training Staff and Team Physicians.
I hereby authorize The University of Cincinnati Athletic Training staff and its Team Physicians to disclose personal health information about me to the following persons or entities:

- UC Head/Assistant Coaches
- Medical Providers
- Insurance Companies
- University of Cincinnati Media Relations Staff
- Parents/Legal Guardians
- Professional Organizations
- UC Strength & Conditioning Staff

I understand that it is necessary for The University of Cincinnati Sports Medicine Staff to have access to my Protected Health Information in order to provide me with the best healthcare.
I understand that it is necessary for head coaches, assistant coaches, strength and conditioning staff, medical care providers, and insurance companies to have access to my Protected Health Information if I am to participate in intercollegiate athletics. Accordingly, I acknowledge that if I do not give permission for my Protected Health Information to be shared with these persons or entities, I may not be allowed to participate in intercollegiate athletics at The University of Cincinnati.
Right to revoke: I understand that I may revoke this authorization at any time by giving written notice to the Assistant Athletic Director for Sports Medicine. I also understand that by revocation of this authorization it may affect my ability to continue to participate in intercollegiate athletics at The University of Cincinnati.

Section C: Individual's Signature

I, _____ have had full opportunity to read and consider the
(Please Print Name)
contents of this authorization, and I understand that, by signing this form, I am conforming my authorization of the use and/or disclosure of my protected health information, as described on this form.

Signature: _____ Date: _____

If this form is signed by a legal representative/ guardian on behalf of the individual, please complete the following (must be completed if above is under the legal age of 18 years):

Legal Representative's Name: _____

Signature: _____ Date: _____

Relationship to Individual: _____