

IUPUI Department of Athletics
STUDENT-ATHLETE AUTHORIZATION FOR THE
DISCLOSURE OF HEALTH INFORMATION

Name of Student-Athlete: _____
Social Security Number: _____
Birth Date: _____
Local Address: _____
City, State, Zip _____
Daytime/Cell Phone: _____

Authorizations:

I authorize: All members of the Indiana University Purdue University Indianapolis ("IUPUI") Sports Medicine Staff, including Athletic Trainers, all IUPUI Team Physicians, or any other physicians or health care professional to release information, records, and reports regarding my medical history, medical status, record of injury and/or surgery, prognosis, diagnosis, record of serious illness, rehabilitation and related personally identifiable health information to the individuals identified below. The information includes injuries or illnesses relevant to past, present, or future participation in athletics at IUPUI.

To use and/or disclose my protected health information (PHI) to: The IUPUI Coaches for my sport, Athletic Trainers, the Athletic Director, and members of the Athletics Staff who have a legitimate need to have information regarding my medical condition.

For The Purpose Of:

- 1 *Advising the above-referenced individuals of the nature, diagnosis, prognosis, or other treatment concerning my medical condition and injuries/illnesses sustained while I am a student-athlete.*
- 2 *Advising media organizations with respect to student-athlete's name, general description of injury and participation status related to an injury or health condition for the purpose of reporting this injury and its effect on participation status.*
- 3 *Data entry of any student-athlete injury or health status reporting program (i.s. SIMS, impact, etc.) established by the Mid-Continent Conference or other such institutions.*
- 4 *Faculty representatives, academic counseling, and compliance personnel may receive information about injuries or health conditions to the extent necessary to explain class absences and other educational consequences of the sports-related injuries or health conditions.*

Acknowledgements:

- The information to be disclosed is protected with as "educational records" by the Family Educational Rights and Privacy Act (FERPA) of 1974 or as "medical records" under Indiana law, and with certain exceptions, may not be disclosed without my consent.
- I am not required to sign this form to receive health care benefits (treatment, payment, enrollment in a health plan, eligibility for benefits).
- I may revoke this authorization at any time by notifying the University in Writing, but if I do, it won't affect any actions the University took in reliance on this authorization before they received the revocation.
- The disclosed information may be subject to re-disclosure and no longer protected by law.
- The University will not receive payment in connection with the uses/disclosures described above.
- If I do not sign this authorization, I may not be allowed to participate in athletics programs at Indiana University Purdue University Indianapolis (IUPUI).

Medical Conditions:

1 Any previous surgeries or hospitalizations: YES NO

If yes when: _____

2 Any sport or non-sport related injuries? YES NO

If yes what:

3 Do you suffer from any diagnosed medical condition (ie diabetes, asmatha, high blood pressure, heart condition)? YES NO

If yes what:

4 Do you suffer from mental health issues or have you ever had a concussion? YES NO

If yes when:

5 Do you have any allergies? YES NO

To what:

By signing this form, I certify that I agree to the disclosure of the records reference above.

Student-Athlete's Printed Name:

Student-Athlete Signature

Date:

Signature of Parent/Guardian

(If Student-Athlete is under 18 years of age)

Date:

A copy of this authorization shall be considered as effective and valid as the original.