CAIRN UNIVERSITY ATHLETICS

Authorization for Release of Medical Information

Name: _____ _____ _____

Last First Middle

By signing this authorization, I authorize Cairn University to use and disclose my health information to the individuals that are identified below and other qualified healthcare providers as deemed necessary.

Certified Athletic Trainer	Athletic Director
Orthopedic Surgeon	Coach(s)
Family Physician	Student Health Services
Physical Therapist	Mental Health Professional
Dentist/Oral Surgeon	Insurance Carrier
Athletic Training Student	

I understand that if the individuals listed above are not health care providers, health plans or health care clearinghouses subject to the Federal Health Insurance Portability and Accountability Act (HIPPA) privacy rules, the health information disclosed pursuant to this authorization may be re-disclosed by such individuals without obtaining my authorization.

I further understand that treatment cannot be denied by refusal to sign this release and that I have the right to revoke this authorization at any time and that the revocation must be in writing and directed to Cairn University. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that have already been made in reliance upon this authorization. I understand that if the above is not followed, I may lodge a complaint to the United States Health and Human Resources Department.

I have had the opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes. I also consent to the Athletic Trainer or athletic training student to treat any injuries that I may incur while participating in school athletics.

_____ _____

Student Athlete Signature Date

_____ _____

Parent/Guardian Signature (under 18 years) Date

Cairn UNIVERSITY
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cairnhighlanders.com

Student-Athlete Authorization/Consent for
Disclosure of Protected Health Information
for NCAA-Related Research Purposes

I, _____ hereby authorize Cairn University
Name of Student-Athlete Name of my Institution

and its physicians, athletic trainers and health care personnel to disclose my protected health information including, without limitation, any information regarding any injury, illness, treatment or participation related to or affecting my training for and participation in intercollegiate athletics to the National Collegiate Athletic Association (NCAA), and its designated employees, agents and/or contractors. I further authorize the NCAA to disclose, and/or use, such information as provided herein.

I understand that my participation and protected health information may be disclosed to, and/or used by, the NCAA and authorized third parties to receive such information for the purpose of using injury, relevant illness and participation information collected from multiple student-athletes and institutions in a manner that does not identify myself or my institution. The information is provided to NCAA committees, athletics conferences and individual schools, and NCAA-approved researchers to evaluate the effectiveness of health and safety rules and policy, and to study other sports medicine questions. Selected de-identified summary (aggregate) data also are made accessible to the general public as a service to further the general understanding of athletics injury patterns and help develop education on student-athlete health topics.

I am making this authorization/consent voluntarily to release my health information otherwise 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). The NCAA and institution are not requiring this authorization/consent to be signed.

I understand that while HIPAA regulations may not apply to NCAA use or disclosure of my injury/illness information, the NCAA is committed to protecting my privacy. I understand that my data will be stored securely within industry standards.

This authorization/consent for transfer of protected health information expires 545 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the director of athletics at my institution. I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

_____ _____
Printed Name of Student-Athlete Signature Date

If a student-athlete is under 18 years of age, parent/legal guardian is also required to sign this form.

_____ _____
Printed Name of Parent/Legal Guardian Signature Date

NCAA/06_05_2018/SH:tas