



Sports Medicine Department

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Name of Student: _____ **Date:** _____

1. The University of Detroit Mercy Sports Medicine Department and its designated agents reserves the right to use and disclose my health and medical information to the following persons or class of persons:
 - Parent(s)/Legal Guardian(s)
 - UDM Coaches and Administrative Staff
 - University Athletic Department's Secondary Athletic Accident Insurance Company
 - Student-Athlete's or Parents'/Legal Guardians' Medical Insurance Company
2. This authorization form will expire one year following the date signed.
3. I understand that I have the right to revoke this authorization at any time, except to the extent that the University has already relied on it. I understand that if I decide to revoke this authorization, I must notify the University of my decision in writing by sending it to: University of Detroit Mercy Sports Medicine Department with attention to the Director of Sports Medicine.
4. I understand that my health information that is disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
5. I understand that the University will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. However, if my health information is needed for enrollment or eligibility determinations or for the University's underwriting or risk rating determinations, then prior to enrollment, the University may condition my enrollment and my eligibility for benefits on whether I sign this authorization.
6. I understand that the University will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. However, if my health information is needed for enrollment or eligibility determinations or for the University's underwriting or risk rating determinations, then prior to enrollment, the University may condition my enrollment and my eligibility for benefits on whether I sign this authorization.
7. I AUTHORIZE THE UNIVERSITY TO USE AND DISCLOSE MY HEALTH INFORMATION AS DESCRIBED ABOVE.
8. I understand that I sign this form voluntarily and that I am fully aware of the University of Detroit Mercy Athletic Department's policy on this matter.

Printed Student-Athlete's Name: _____

Student-Athlete's Signature: _____

Student-Athlete's Date of Birth: _____

Student-Athlete's Social Security Number: _____

Signature of Parent/Guardian (If Student-Athlete is under 18): _____

