UNIVERSITY OF NORTH FLORIDA DEPARTMENT OF ATHLETICS

Authorization for Use, Disclosure, and Release of Health Information

Student-Athlete / Patient Print Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION:

I authorize the following persons (or class of persons) to make authorized use and/or disclosure of my protected health information: UNF Athletic Medicine Department personnel and support staff, including Team physician(s), consulting physicians, athletic trainers and assistants, physical therapists and assistants, and UNF Student Health Services, physicians, counselors, and support staff.

RELEASE OF PROTECTED HEALTH INFORMATION TO:

I authorize the following persons (or class of persons) to receive my protected health information: University of North Florida Athletic Directors, Associate and Assistant Athletic Directors, coaches, Athletics Department staff members, UNF athletic trainers and Athletic Medicine Department personnel, third-parties for insurance and billing purposes; and other healthcare providers for diagnosis or treatment purposes.

INFORMATION TO BE RELEASED:

- ☐ Entire Record (excluding special permission records)
- ☐ Treatment or Tests
- ☐ Allergy Records
- ☐ Consultations
- ☐ Medical History, Examination, Reports
- ☐ Hospital Records Including Reports
- ☐ Laboratory Reports
- ☐ Immunizations
- ☐ Surgical Records
- ☐ X-ray Reports
- ☐ Prescriptions
- ☐ Other (Specify): _____

In compliance with Florida and Federal Statutes, which may require special permission to release otherwise privileged information, please release records pertaining to:

- ☐ Mental Health
- ☐ HIV (AIDS)
- ☐ Developmental Disabilities
- ☐ Sexually Transmitted Disease
- ☐ Alcoholism
- ☐ Drug Abuse
- ☐ Other (Specify): _____

For the following date(s): _____

PURPOSE FOR DISCLOSURE: (Check applicable categories)

- ☐ Further Medical Care
- ☐ Medical Ability and Fitness to Participate in Athletics
- ☐ Insurance Eligibility / Benefits
- ☐ Legal Investigation or Action
- ☐ Health and Injury Status for Athletics
- ☐ Other (Specify): _____
- ☐ Changing Physicians

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization. However, redisclosure by school officials may be subject to student education records privacy laws.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be Used or Disclosed- I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Program Coordinator.

Right to Receive Copy of This Authorization- I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Refuse to Sign This Authorization- I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to Withdraw This Authorization- I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Program Coordinator. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until one year from the date signed, unless another date is specified here: _____.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Student-Athlete / Patient Signature _____ Date _____

Witness Signature _____ Witness Print Name _____