Student-Athlete Authorization/Consent
For
Disclosure of Protected Health Information

I hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel representing the University of Georgia and the University of Georgia Athletic Association to release information regarding my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be released to other health care providers, parents/guardians, hospitals and/or medical clinics and laboratories, athletic coaches, strength and conditioning coaches, medical insurance coordinators, insurance carriers, medical supply vendors and/or service companies, academic counselors, athletic and/or university administrators, chaplains and/or clergy members, NCAA Injury Surveillance System, sports information staff and members of the media.

I understand that my authorization/consent for the disclosure of my protected health information is a condition for participation as an intercollegiate athlete for the University of Georgia. I understand that my protected health information is 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) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment.

I understand that I may revoke this authorization/consent at any time by notifying in writing the Director of Sports Medicine, but if I do, it will not have any effect on actions the University of Georgia or the University of Georgia Athletic Association took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent expires six (6) years from the date it is signed.

_____ _____ _____

Name of Student-Athlete (print or type) Signature of Student-Athlete Date

_____ _____

Social Security Number of Student-Athlete Date of Birth of Student-Athlete

_____

Signature of Parent/Legal Guardian (if student-athlete is under 18 years of age) Date

Student-Athlete Authorization/Consent
For
Disclosure of Protected Health Information
To
Sports Information Staff/Members of the Media For Specific Medical Condition or Injury

I hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel representing the University of Georgia and the University of Georgia Athletic Association to release information regarding my protected health information to sports information staff and members of the media.

I understand that my authorization/consent is subject to the limitations checked below:

1. Confined to records concerning the following medical condition or injury:

_____

2. Covering records for the period from ____/____/____ to ____/____/____.
3. Confined to the following specified information: (check all that apply)

- o medical condition
- o medical status
- o athletic participation status
- o prognosis
- o consultation
- o operative notes
- o discharge summary
- o lab reports
- o pathology reports
- o EKG/echocardiogram
- o medications
- o history and physical
- o x-ray reports
- o MRI/CT reports
- o other special tests: _____ _____
- o progress notes
- o other: _____

I understand that my protected health information is 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) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I understand that I may revoke this authorization/consent at any time by notifying in writing the Director of Sports Medicine, but if I do, it will not have any effect on actions the University of Georgia or the University of Georgia Athletic Association took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent shall expire on ____/____/____ or ninety (90) days from the date it is signed.

_____ _____ _____
Name of Student-Athlete (print or type) Signature of Student-Athlete Date

_____ _____
Social Security Number of Student-Athlete Date of Birth of Student-Athlete

_____
Signature of Parent/Legal Guardian (if student-athlete is under 18 years of age) Date