

BUCKNELL UNIVERSITY DEPARTMENT OF ATHLETICS



Student-Athlete Authorization /Consent for Disclosure of Protected Health Information to Bucknell University

I, _____, hereby authorize the disclosure and/or use of my protected health
(Name of Student-Athlete)

information and any related information regarding any injury or illness that arises during my training for and participation in intercollegiate athletics to Bucknell University and its physicians, athletic trainers, health care personnel, employees, agents, and business associates (hereinafter "Bucknell") for purposes, including, but not limited to:

- My treatment, including the provision, coordination, or management of health-care and related services to me by one or more health-care providers.
- Payment activities related to my injury or illness, for Bucknell as well as other health-care providers and health plans.
- Health-care operation purposes as well as certain health-care operation purposes of other health-care providers and health plans.
- To disclose my protected health information to someone involved in my care or payment for my care such as a spouse, a family member, or close friend.
- To notify, or to assist in the notification of, a family member, a personal representative, or another person responsible for my care, regarding my location, general condition, or death.
- When required by federal, state, or local law.
- For judicial and administrative proceedings.

I understand that my injury/illness 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 my signing of this authorization/consent is voluntary and that Bucknell will not condition any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for in this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA or conference athletics.

This authorization/consent expires 380 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 athletic director at my institution. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent.

Student-Athlete's Printed Name

Student-Athlete's Signature

Date