

CLEVELAND STATE UNIVERSITY

AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

Photocopy or facsimile of the original authorization will be considered as valid as the original

ATHLETE:

Athlete's Name

Date of Birth

Street Address

City/State/Zip Code

AUTHORIZES:

Information to be released from:

Insurance company, hospital, physician, or other person as needed.

Information to be released to:

All Cleveland State University Athletic Department, the medical staff, athletic trainers, insurance coordinators, health care providers, and insurance carriers for the claimant.

Name of Healthcare Provider/Plan/Other

Name of Receiver

Street Address

Street Address

City/State/Zip Code

City/State/Zip Code

INFORMATION TO BE RELEASED INCLUDES:

_____ Include all information concerning my health that impacts my ability to participate in sports. This may include all information with the respect to injuries (such as sprains, strains), surgeries (such as ACL reconstruction, rotator cuff repair), concussions (Impact testing results), medical conditions (such as asthma), policy coverage, medical history, consultation, prescription, treatment, or copies of all medical records.

_____ Other (Only information as listed) _____

NEED FOR THE DISCLOSURE:

_____ The purpose of the release of this information is:

- ? To inform the Medical Staff of my health related limitation and abilities to continue to participate in sporting events.
- ? To inform Medical Staff with information about my injury to help me participate in sporting events safely.

I understand that if the person(s) and/or organization 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 re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect of 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 health information department. **Right to Receive Copy of this Authorization-** I understand that if I agree to sign this authorization, which I am not required to do so, I must be provided with a signed copy of the form. **Right to Refuse to Sign this Authorization-** I understand that my signing of this consent form is voluntary and that Cleveland State University will not condition any health care treatment or payment, enrollment in health plan, or receipt of any appropriate benefits on whether or not it is provided this consent. I understand that I am not required to sign this authorization in order to be eligible for participation in NCAA or Horizon League athletics. **Right to Withdraw this Authorization-** I understand that written notification to the Athletic Director at Cleveland State University 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 Athletic Medicine Department. 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 had already made in reference to this authorization.

EXPIRATION DATE: This authorization is good for 380 days from the signed date. I have had opportunity to review and understand the content of this authorization form. By signing this authorization I am confirming that it accurately reflects my wishes.

Signature of Athlete/Legal Representative

Date

(If signed by other than athlete, state relationship and authority in which to sign for athlete, i.e. deceased, minor, incompetent)

Request filled by: _____ (Employee) Date: _____ Records Released: _____