

**AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION**

I, \_\_\_\_\_ (student-athlete), hereby authorize The University of Dayton and/or health care professionals acting on its behalf to (check Option A or B):

A. \_\_\_\_ Disclose any protected health information being used or disclosed for the diagnosis, monitoring, treatment of injuries or other conditions, and for other athletic-related purposes to The University of Dayton, its Division of Athletics personnel, coaches, athletic trainers, other treating health care professionals, business associates, Athletic Communications, approved media contacts, consultants, and volunteers of the program, or

B. \_\_\_\_ Use only the following protected health information (check all that apply):

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|--|--|--|
| <input type="checkbox"/> Final Diagnosis     | <input type="checkbox"/> Operative Report(s)     | <input type="checkbox"/> Progress Notes          |
| <input type="checkbox"/> History/Physical    | <input type="checkbox"/> Consultation(s)         | <input type="checkbox"/> Physician Orders        |
| <input type="checkbox"/> Discharge Summary   | <input type="checkbox"/> X-ray Reports           | <input type="checkbox"/> EKG Interpretations     |
| <input type="checkbox"/> Pathology Report(s) | <input type="checkbox"/> Laboratory Reports      | <input type="checkbox"/> Copies of Entire Record |
| <input type="checkbox"/> Status Reports      | <input type="checkbox"/> Other (Please Specify): |  |

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This authorization shall be in force and effect until I graduate or otherwise separate from The University of Dayton, at which time this authorization to use or disclose this protected health information expires.

I understand a copy of The University of Dayton’s Notice of Privacy Practices is available to me. I understand I may discuss any concerns I may have about the use or misuse of my health information with The University of Dayton’s privacy officer or other appropriate personnel.

I understand that The University of Dayton assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release The University of Dayton, its agents and employees, and the health care professionals acting on its behalf, from all legal liability that may arise from this authorization.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Head Athletic Trainer at The University of Dayton, 300 College Park, Dayton, Ohio, 45469. I understand that a revocation is not effective to the extent that The University of Dayton has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent state law provides greater access rights).
- Refuse to sign this authorization.

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian (if minor)

\_\_\_\_\_  
Sport