

**SAINT LOUIS UNIVERSITY SPORTS MEDICINE**  
**Authorization for Release of Protected Health Information**

Student-Athlete Name: \_\_\_\_\_  
*First Middle Initial Last*

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Student ID# \_\_\_\_\_ Sport: \_\_\_\_\_

1. I hereby acknowledge that I received a copy of the Saint Louis University Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Student Athlete Date

2. I hereby grant permission to the Sports Medicine Staff of Saint Louis University Department of Athletics to release health information pertaining to my fitness to participate in SLU Intercollegiate Athletic activities to Athletic Department administrators, coaches, and administrative staff responsible for assessing or approving my participation to the extent the information is needed for that purpose.

\_\_\_\_\_  
Signature of Student Athlete Date

3. I hereby grant permission to SLU Department of Athletics administrators and coaches to release to the news media the nature of any athletic-related injury or illness and my expected rehabilitation period, if any, for purposes of addressing my participation in intercollegiate athletic activities. This information may also be released to my parent or guardian.

\_\_\_\_\_  
Signature of Student Athlete Date

4. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Director of Athletics. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that SLU Department of Athletics may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the persons(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release or fax of this release shall be as valid as this original release. If I authorize SLU to fax the information, I realize there are inherent risks in faxing Protected Health Information. I understand a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

\_\_\_\_\_  
Signature of Student Athlete Date

EACH AUTHORIZATION EXPIRES ONE CALENDAR YEAR FROM SIGNATURE DATE.