Appendix Z
Student-Athlete Authorization/Consent for
Disclosure of Protected Health Information to the
National Collegiate Athletic Association for
Monitoring and Research of Sports Injuries/Illnesses

I, _____hereby authorize_____
Name of student athlete Name of Institution

And its physicians, athletic trainers, and health care personnel to disclose my protected health information and any related information regarding to any injury or illness or participation related to my training for and participation in intercollegiate athletics to the National Collegiate Athletic Association (NCAA) and its employees or agents.

I understand that my participation and protected health information will be used by the NCAA's Injury Surveillance System (ISS), a longitudinal surveillance database maintained by the NCAA for the purpose of monitoring injuries resulting from training for or participation in athletics. The ISS provides NCAA committees, athletic conferences, individual schools, and NCAA approved researchers with injury participation information that does not identify individual athletes or schools. The data provides the Association and other groups with information resource upon which to base and evaluate the effectiveness of health and safety rules and policy, and the study other sports medicine questions. Selected de-identified summary (aggregate) data also are made accessible to the general public as a service to further the general understanding of athletic injury patterns.

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPPA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPPA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition or withhold any health care treatment or payment, enrollment in a health plan or receipt of benefits (if applicable) or whether I provide the consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA athletics.

I understand that while HIPPA regulations may not apply to the NCAA's use or disclosure of my injury/illness information, the NCAA is committed to protecting my privacy. I understand that the protected health information and any personal identifiers will be encrypted while being transmitted from my institution to the NCAA and that all data will be stored on a secure server at the NCAA national office in Indianapolis, Indiana. I further understand that neither the NCAA nor the ISS will identify me personally in an publication or disclosure of research results.

This authorization/consent for transfer of protected health information expires 545 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 takes effect on its request date and does not affect any action taken prior to that date.

_____ _____ _____
Printed Name Signature Date