

Cuesta College Athletics
Authorization for Use, Disclosure, and Release of Health Information

Student Athlete Name (please print)

Date of Birth

Address

City

State

Zip

Authorization for use and/or Disclosure of Health Information:

I will authorize the following persons (or class of persons) to make authorized use and/or disclosure of my protected health information: Team physician(s), consulting physicians, athletic trainers and assistants, physical therapists and assistants, Cuesta College Sports Medicine personnel and support staff.

Release of Protected Health Information to:

I authorize the following persons to receive my protected health information: Cuesta College Athletic Directors, Assistant Athletic Directors, Coaches, Parents, Athletic department staff members, Athletic Trainers and staff, third-parties for insurance and billing purposes; and other health care providers for diagnoses and treatment purposes.

Information to be Released Include:

Entire medical record, treatment or tests, allergy records, consultations, medical history, examinations and reports, hospital records including reports, laboratory reports, immunizations, surgical records, X-ray reports and prescriptions.

Purpose for Disclosure

Further medical care, medical ability and fitness to participate in athletics, treatment, insurance eligibility and benefits, legal investigation or action, health and injury status, and to avert serious threat to health and safety.

I understand that if the person(s) and/or organization(s) 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 redisclosed without obtaining my authorization, however, redisclosure by school officials may be subject to student education records privacy laws.

Your Rights With Respect to this Authorization:

Right to inspect or 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 athletic trainer.

Right to Receive a copy of this Authorization; I understand that if I agree to sign this authorization, which I am not required to do, I can obtain a signed copy of this form by request.

Right to Refuse to Sign This Authorization; I understand that I am under no obligation to sign this form and that the person(s) and /or organizations(s) listed above who I am authorizing to use and /or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care on my decision to sign this authorization.

Right to Withdraw This Authorization; I understand written notification 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 trainer. 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 have already made in reference to this authorization.

Expiration Date; This authorization is good for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Student Athlete Signature

Date