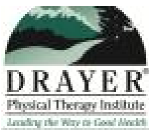

STUDENT ATHLETE AUTHORIZATION TO RELEASE INFORMATION

The content of my medical record is confidential and protected under state and federal law as per the HIPAA Notice of Privacy Practice posted in the school athletic training room. I understand that in an effort to provide quality athletic training services and maintain my safety, it is imperative that the athletic trainer for my school, who is employed by Drayer Physical Therapy Institute (DPTI), and any other DPTI employee who assists the athletic trainer with my care, keep other school related personnel informed, on a need to know basis, of my health care status and pertinent health care needs related to my participation in athletics.

Therefore, I, or my parent/legal guardian, hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Student Athlete's Name: ____ **Date of Birth:** ____________

Organization Providing the Information: DRAYER PHYSICAL THERAPY INSTITUTE

Organization(s) or Person(s) Receiving the Information: Head Coach, Assistant Coach(es), Athletic Director, Assistant Athletic Director, School Nurse, Physical Education Teacher, Equipment Manager, School Employed Athletic Trainer, Personal Trainer, Principal, Vice Principal(s), Student Athletic Trainers.

Other:____

Specific Description of Information Disclosed: √ Athletic Training Medical Record

Purpose of Disclosure: Coordination of Student Athlete's Athletic Training and Medical Services in conjunction with participation in sports, Phys. Ed. Class and any other relevant School activities.

This Authorization is not for marketing purposes.

By signing and initialing the following statements, I authorize the release of such information to the persons listed above.

1. I understand this Authorization will expire 2 years from date of signature or on the following event: Termination of the student athlete/athletic trainer relationship. Initials: _____
2. I understand that I may revoke this Authorization at any time by notifying DPTI's Privacy Officer in writing, but if I do, it will not have any effect on any actions DPTI took before they received the revocation. Initials: _____

(Authorize)________________________________ ______________ ______________________________________

Signature of Athlete, Athlete's Parent or Legal Guardian | Date | Relationship to Student Athlete

You may refuse to sign this Authorization. We cannot condition treatment on your signing this Authorization.

By signing and initialing the following statements, I do not authorize the release of such information to the persons listed above.

1. I understand that by **not signing** this Authorization, I have limited the athletic trainers' ability to release specific health information regarding injuries sustained or pre-existing conditions, on a need to know basis, to the persons listed above. Initials: _____
2. I have read and understand the purpose of this form and **DO NOT** authorize the release of such information to the persons listed above. Initials: _____

(Decline)__________________________________ ______________ ______________________________________

Signature of Athlete, Athlete's Parent or Legal Guardian | Date | Relationship to Student Athlete

For Internal Use Only **Accounting of Disclosures**

Date Request is Made	Date of Release by DPTI (w/in 60 days of request)	Specific PHI Released (if other than entire record	Released By (employee's signature)

Drayer Physical Therapy Institute 8205 Presidents Drive Hummelstown, PA 17036 717-220-2100