



**Oxford College Sports Medicine**  
 Phone (770) 784-4691

## AUTHORIZATION FOR USE/DISCLOSURE OF STUDENT ATHLETE PROTECTED HEALTH INFORMATION

*Effective April 2003, federal guidelines contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require that patients (or parent or guardian if the patient is a minor) give specific authorization to healthcare providers and healthcare organizations regarding certain uses and disclosures of their individually identifiable health information, also known as Protected Health Information. Generally, Oxford College Sports Medicine team physicians and certified athletic trainers use and disclose a student athlete's Protected Health Information for purposes of treatment (including interactions between trainers and team physicians and interactions with Emory specialty physicians and other outside healthcare providers) and communications with coaches and parents/guardians regarding a student athlete's participation status for practice and competition. In order that we may have permission to use and disclose your Protected Health Information, including the information in your Oxford College Pre-participation Sports Physical Exam, for these purposes, we ask that you (or your parent or guardian if you are under 18 years of age) please complete this 2-page authorization for the Oxford College Sports Medicine Program. You should keep the two yellow copies (which includes your signature on Page 2) of this Authorization for your personal records. You will also be given (or have already been given) a "Notice of Privacy Practices" by Oxford College Student Health Services (OCSHS). This Notice delineates more fully how health information about you (as a student athlete and a patient at OCSHS) may be used and disclosed by Oxford College of Emory University and how you can get access to your individually identifiable health information.*

I hereby authorize the use or disclosure of any of my health information, including health information that identifies or could be used to identify me (or the Patient identified below, if I am signing this Authorization as the parent or personal representative of a patient) as described below. (Throughout this form, all health information that is subject to this Authorization is referred to as "Protected Health Information.")

**Student Athlete's Name:** \_\_\_\_\_ **Student ID # (if known):** \_\_\_\_\_

**Protected Health Information that May be Used/Disclosed:** The Protected Health Information that may be used or disclosed consists of the following information (please choose only one option):

\_\_\_\_\_ All Protected Health Information contained in my training room medical record, including, but not limited to, my Oxford College Pre-participation Sports Physical Exam and physician/trainer treatment notes, **or**

\_\_\_\_\_ Information in my training room medical record limited to the following (specify type of Protected Health Information that may be disclosed, such as trainer's notes, physicians' notes, laboratory results, radiology reports, etc.): \_\_\_\_\_

**Persons/Entities Authorized to Use/Disclose the Protected Health Information:** The person(s) or class of persons who is/are authorized to make the use/disclosure of this Protected Health Information is/are (you may choose more than one option):

\_\_\_\_\_ Oxford College Sports Medicine physicians and certified athletic trainers

\_\_\_\_\_ Other (describe): \_\_\_\_\_

**Purpose(s) for Which the Protected Health Information May be Used or Disclosed:** The Protected Health Information may be used or disclosed for the following purpose or purposes (you may list more than one):

\_\_\_\_\_ To provide Oxford Sports Medicine physicians and certified athletic trainers with Protected Health Information for purposes of providing health care to me (or the student athlete listed above) while I am (the student athlete is) a student athlete at Oxford College; to provide information to Oxford College coaches and/or my parent/guardian regarding participation status for practice and competition; to provide Protected Health Information to other Emory specialist physicians, other outside health providers and to other third parties (such as my health insurance company) for purposes of providing healthcare to me and billing.

\_\_\_\_\_ Other (describe): \_\_\_\_\_

**Authorization for Use/Disclosure of Student Athlete Protected Health Information (Page 2)**

**Student Athlete's Name:** \_\_\_\_\_ **Student ID # (if known):** \_\_\_\_\_

**Persons/Entities by Whom the Protected Health Information May be Used/to Whom it May be Disclosed:** The Protected Health Information may be used by or disclosed to the following persons, departments, agencies, and/or companies (you may choose one or both options):

\_\_\_\_\_ Oxford College Sports Medicine trainers and team physicians, Oxford College Student Health Services, Emory University Hospitals and The Emory Clinic (for purposes of treatment, payment and healthcare operations); Oxford College coaches and my parent/guardian (for communication purposes regarding my status for practice and competition); health insurers and other healthcare providers (for purposes of treatment and/or billing)

\_\_\_\_\_ Other persons/entities limited to the following (describe): \_\_\_\_\_  
\_\_\_\_\_

**Expiration Date/Event:** This Authorization will expire on the date or upon the occurrence of the event set forth below (please choose only one option):

\_\_\_\_\_ When I revoke this Authorization in writing as described below.

\_\_\_\_\_ On the following Expiration Date: \_\_\_\_\_, or upon the occurrence of the following event (for example, two years after I am no longer a student athlete Oxford College): \_\_\_\_\_

**Re-Disclosure of Protected Health Information and Revocation of Authorization:** I understand that any Protected Health Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may not be protected by federal privacy regulations. I understand that I may revoke this Authorization in writing at any time by sending a letter stating that I revoke this Authorization to: **Oxford College**. After I revoke this Authorization, my (the student athlete's) Protected Health Information will not be used or disclosed except to the extent that use or disclosure was already made in reliance on this Authorization or to the extent that use or disclosure is required and permitted by law.

**Provision of Health Care Not Conditioned on Authorization:** I understand that my receipt of health care (or the student athlete's receipt of health care) from the trainers and physicians of Oxford College Sports Medicine is not conditioned on my signing of this Authorization, unless the health care that I am (the student athlete is) to receive is solely for the purpose of creating Protected Health Information for disclosure to a third party (for example, performance of a sports pre-participation physical examination, the results of which the student athlete wishes to have disclosed to Oxford coaches for the purpose of determining eligibility for participation).

**Parent or Personal Representative Signing on Behalf of Patient (initial below if applicable):**

\_\_\_\_\_ I am a parent signing this form on behalf of my minor child who is the student athlete referenced in this form. I certify that I have all legal right and authority to sign this form and make this authorization on behalf of my minor child.

\_\_\_\_\_ I am the personal representative of the person who is the student athlete referenced in this form. I have all legal right and authority to sign this form and make this authorization on behalf of the Patient. My authority to act for the Patient comes from (please describe, such as power of attorney for health care, court order, etc.): \_\_\_\_\_

**After I sign this form, I will keep or receive a copy of it and a copy also will be placed in my (the student athlete's) Training Room medical record.**

\_\_\_\_\_  
**Signature of Student Athlete**

OR

\_\_\_\_\_  
**Signature of Parent or Personal Representative**

\_\_\_\_\_  
**Name of Parent or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**