



180 West Brooks
Norman, Oklahoma 73109-6011
Ph. (405) 325-8331 Fax (405) 325-8388

Authorization Form
For Uses and Disclosures of Patient Protected Health Information

STUDENT-ATHLETE: _____ **SPORT:** _____

SOCIAL SECURITY NUMBER: _____ **DATE OF BIRTH:** _____

I hereby authorize University of Oklahoma Department of Intercollegiate Athletics to release my protected health information. Protected health information may include:

- i. injury or illness relevant to past, present or future participation in intercollegiate athletics at the University of Oklahoma
- ii. information contained in my personal medical record unrelated to my participation in intercollegiate athletics at the University of Oklahoma
- iii. information concerning my medical status, medical condition, injuries, prognosis, diagnosis and other related personally identifiable health information, including injury reports, test results, x-rays, progress reports and any other documentation regarding my health status

Authorization is granted for release of my protected health information to:

- the media, including specifically the University of Oklahoma Media Relations Office, to advise the print, radio, television and other media of the nature, diagnosis, prognosis or treatment concerning my medical condition and any injuries or illnesses for the purpose of reporting on it while I am a student-athlete
- professional athletic teams, their scouts, athletic trainers, physicians, servants, or employees for the purpose of making decisions regarding my prospect as a professional athlete
- my parents/guardian and/or spouse for the purpose of assisting me in making healthcare decisions while I am a student-athlete
- the coaches, assistant coaches, and other athletic staff so that they may make decisions regarding my athletic ability and suitability to compete while I am a student-athlete
- my teammates so that they may be aware of limitations that I may be under while I am a student-athlete
- the student athletic trainers and other students who are participating in the provision of sports medicine healthcare to assist and participate in the provision of healthcare to me while I am a student-athlete
- amateur athletic organizations for the purpose of making decisions regarding my prospect as an athletic participant
- academic departments including specifically the University of Oklahoma Athletic Student Life Office for the purpose of making decisions regarding my ability and suitability to perform academically while I am a student-athlete
- the Big XII Conference and National Collegiate Athletic Association for the purpose of making determination regarding my eligibility status while I am a student-athlete
- applicable insurance providers for the purpose of processing insurance claims while I am a student-athlete

This authorization will automatically expire six years from the date it is signed.

Please Note the Following:

You may refuse to sign this authorization. Your refusal will *not* affect your ability to obtain treatment or payment.

1. If the persons or entities who are authorized to receive the information above are *not* health care providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws would no longer protect the disclosed health information.
2. Once you sign this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. Any revocation will not be effective as to information already disclosed in reliance on the authorization. You can *revoke* this authorization by delivering a dated and signed letter to the Head Athletic Trainer addressed to:

**Scott Anderson, ATC
Head Athletic Trainer
University of Oklahoma
180 West Brooks
Norman, OK 73019**

3. The information authorized for release may include records which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (“AIDS”) and/or mental health information.
4. The University of Oklahoma will not receive compensation for its use or disclosure of your protected health information.

Printed Name of Student-Athlete

Signature: _____ Date: _____
Student-Athlete or Legal Representative

Capacity of * Legal Representative (if applicable): _____

*** May be requested to provide verification of representative status.**