



AVE MARIA UNIVERSITY

DEPARTMENT of SPORTS MEDICINE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Student Athletes Name: _____

Date of Birth: _____ **Social Security Number:**

By signing this form, I authorize Ave Maria Universities Department of Sports Medicine, to act in the capacity of an approved medical provider, to use and disclose the above named individuals health information as deemed necessary to further the care of this particular athlete.

I understand that the individuals, to which this information is released, are health care providers or health care clearinghouses subject to Federal Health Insurance Portability and Accountability Act (HIPPA) privacy rules. The health information disclosed pursuant to this authorization may be redisclosed by such individuals without obtaining my authorization.

I further understand that I have the right to revoke this authorization at any time, and that the revocation must be in writing and directed to Ave Maria Universities Department of Sports Medicine. I am aware that my revocation of such information will not pertain to the health information disclosed made in reliance upon this particular authorization. This authorization will remain in effect for one calendar year or until this individual graduates or chooses to leave the university.



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

Participants Signature: _____ **Date:**

If signed by a Personal Representative, please complete the following:

Name of Representative (Please Print): _____

Relationship to the Participant, or nature of authority (Guardian, Parent, Power of Attorney): _____

Phone Number where you can be contacted: _____

Personal Representatives Signature:

Date: _____