



RELEASE OF MEDICAL INFORMATION AUTHORIZATION

Under the Health Insurance Portability and Accountability Act (HIPPA) of 1996, I have certain rights regarding the use and disclosure of my protected health information.

I authorize the certified athletic trainer to discuss injuries/illnesses and insurance information related to my participation as a Dillard University scholar-athlete and release any applicable medical information or records relating to those injuries to the team physician, Dillard University Office of Health and Wellness, and other consulting qualified health care providers as deemed necessary within their scope of practice. I understand this authorization form must be filled out completely and signed in order to be considered valid. A copy that has not been altered will be considered a valid original.

CONSENT FOR TREATMENT

I give authorization to the certified athletic training staff , team physician , as well as those professional personnel designated by them, to evaluate and treat any injuries that occur during athletic participation at Dillard University. This includes immediate first aid and treatment, physical exam, admission to hospital, X-rays, emergency surgery, administration of drugs and/or injections and follow-up and rehabilitation in the athletic training room.

I have read this form and I understand its contents at this date.

Name – Printed

Sport(s)

Signature

Social Security #

Parent/Guardian Signature (if under 18 yrs of age)

Date