



Aquinas College Athletic Training

Authorization to Disclose Private Health Information

I authorize the athletic training staff, team physicians, and other health care providers who are affiliated with Aquinas College and from whom I received health care treatment to disclose my health information (written and/or verbal), when requested to do so, for the purposes of treatment, or for any other purpose which is permitted or required by law.

Personal health information includes, but is not limited to: information involving the nature and treatment of an injury/illness, medical history, insurance coverage and copies of all hospital and medical records. This information will be released ONLY for the purposes of further treatment (referrals to specialists or other health care providers) or disclosure of participation status to your team's coaches for your health and safety.

In order to maintain continuity of care and provide participation status updates to athletic department personnel, I hereby authorize the athletic training staff to disclose injuries/illnesses contained in my student-athlete medical file, including medical conditions, treatment and rehabilitation status, and participation restrictions to the following entities:

- Team Physicians: Metro Health Sports Medicine
- Aquinas College coaching staff for my sport
- Aquinas College Athletic Director: Terry Bocian
- Aquinas College Sports Information Staff
- Parents/Guardians/Spouse: (Names) _____

▪ **INITIAL TO DECLINE PARENT/GUARDIAN/SPOUSE AUTHORIZATION** _____

This authorization expires one (1) year from the date signed. This consent can be withdrawn at any time, by the student-athlete, in writing.

Date _____

Athlete's Name _____
(Print)

Athlete's Signature _____

Parent/Guardian Signature _____
(IF ATHLETE UNDER 18 YEARS OLD)