

# HIPAA Privacy Authorization Form

\*\*Authorization for Use or Disclosure of Protected Health Information  
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.  
Parts 160 and 164)\*\*

**\*\*1. Authorization\*\***

I authorize \_\_\_\_\_ (Athletic Trainer) to use  
and disclose the protected health information described below to:

**Scholastic Rowing Association of America (SRAA).**

**\*\*2. Effective Period\*\***

This authorization for release of information covers the period of healthcare  
from:

**\_\_August 1, 2014\_\_ to \_\_May 24, 2015\_\_.**

**\*\*3. Extent of Authorization\*\***

1. I authorize the release of my health assessment and information pertinent to the SRAA Lightweight Health Certificate.
2. This authorization shall be in force and effect until \_\_May 24, 2015\_\_ at which time this authorization expires.
3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
4. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

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Signature of patient or personal representative

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Printed name of patient or personal representative and his or her relationship to patient

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Date