Form 4

COLORADO COLLEGE SPORTS MEDICINE

INDIVIDUAL AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section 1:

I hereby request and authorize the use or disclosure of my (or my child's, if under 18) "protected health information: (PHI) as described below.

Patient Name	Patient Date of Birth	Patient Social Security #
Patient Address	City, State, Zip Code	Patient Phone #
Subscriber/Member Name (if different from patient)	Subscriber/Member ID #	

Section 2:

The individual(s) or entity(ies) authorized to disclose the protected health information is/are:

Colorado College Sports Medicine Staff

Jason Bushie, MA, ATC
Cindy Endicott, MS, ATC, PT
Holly Fry, MS, ATC
Robyn Kadel, ATC
Ian Wood, MS, ATC

Athletic Insurance Coordinator — Celina Swedlund

Section 3:

The types of protected health information which may be disclosed include:

Claims records, claims status, patient management records, pertaining to all injuries and illnesses that occur during Aug. 1, 2012-July 31, 2013.

Medical records pertaining to all injuries and illnesses, occurring between Aug. 1, 2012 and July 31, 2013.

Section 4:

The purpose for which the disclosure may be made is:

At the request of the individual.

Section 5:

You have the right to revoke this authorization at any time, by sending written notice to the individual or entity listed above in Section 2. If you revoke this authorization after protected health information has been disclosed, the disclosing entity will not be able to take back information previously disclosed.

Please sign and print your name below indicating that you understand and accept the statement above.

Patient's name (printed)	Patient's signature

Section 6:

This authorization and request for disclosure is mandatory in order to compete in varsity intercollegiate sports at Colorado College.

I hereby request and authorize the use or disclosure of my (or my child's) "protected health information": (PHI) as described above. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulation.

Signature of health plan member/patient	Date

Patient's name (printed)

*If this authorization is being signed by the legal representative of the individual to whom the protected health information pertains, you must furnish a copy of the power of attorney or other relevant document designating you as the legal representative.