2016-17 FAIRFIELD HIPPA RELEASE FORM FOR:

Student Name:_____ Grade:_____

Use and Disclosure of Protected Health Information
to Persons Involved in the Students Care

Regional Rehabilitation Center
1500 Provident Dr
Warsaw, IN 46580

FILL IN ONE OF THESE BOXES →→→→→→→→→→→→→→→

(consent for student athletes 18 years and above)

I _____a student athlete participating in the school sports program
(Student-Athlete 18 or older print your name)

OR

(consent for student athletes UNDER 18 years of age)

I _____ as the Parent, Guardian or Legal Representative of
(print parent/guardian name)

_____
(print name of student)

Student-Athlete turns 18 on ___/___/_____ (mm/dd/yyyy)

understand that I have the right to agree, restrict or object to the disclosure of Protected Health Information (PHI) by the Athletic Trainer to members of the school athletic department. This includes but is not limited to the Athletic Director, Coach and members of the coaching staff. I understand the information disclosed by this authorization may be subject of re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

By my signature, I give the Athletic Trainer permission to disclose PHI to members of the school's athletic department. I understand that the information disclosed will be limited to the injury/illness affecting athletic participation. I understand that I can revoke this permission to disclose at any time by submitting such request to the Athletic Trainer in writing. The revocation of permission will apply from the date of receipt and is not retroactive.

This permission is in effect for the athletic period: **July 1, 2016 through June 30, 2017**

(COMPLETE ONLY For Student-Athletes 18 years and older)
I agree to permit the Athletic Trainer to share the above granted information with my parents and/or individual(s) I so designate Yes____ No____ Initials:_____

Additional individuals who may receive PHI:

_____ _____

_____ _____

Parent Signature: _____

Date:_____

Authority to sign if not parent:_____
(Guardian or Legal Representative)