UHealth UNIVERSITY OF MIAMI HEALTH SYSTEM | SPORTS MEDICINE INSTITUTE

Authorization for Release of Medical Information – Student-Athlete

Student Information:

Last Name	First Name	MI	
Street Address	City	State	Zip
Birth Date	Phone Number		
Name of School Attended by Student		Anticipated Graduation Date	

Authorizes: UHealth Sports Medicine Licensed Athletic Trainers

To Use or Disclose: Information concerning the Student's health and medical condition, including records of evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in School-sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in School-sponsored activities.

Disclosed To: The School's administrators, athletic directors, coaching staff, athletic trainers, physical education teachers, nurses or other members of the School's staff, and officiating staff at athletic events, as necessary to evaluate and determine the Student's eligibility to participate in School-sponsored activities, including but not limited to sports programs, physical education classes or other classroom activities.

Purpose for Disclosure: The above-described information may be released or disclosed to the above-named persons to advise of: (a) the Student's health or injury status, or need for further medical treatment; (b) restrictions on a Student's ability to participate in School sponsored activities, including but not limited to practice sessions, training and competition; and (c) how a Student may safely participate in School-sponsored activities.

Expiration Date: This Authorization will expire when the Student is no longer enrolled as a student at the School or when revoked, whichever occurs first.

By Signing Below: I authorize the use and/or disclosure of my (or my Student's) health information as described on this Authorization. I understand that School has requested this Authorization to make certain decisions about the Student's health and ability to participate in

certain School-sponsored and classroom activities, and that the School is not a health care provider or health plan covered by federal HIPAA privacy regulations. I further understand that the information described above may be re-disclosed and may not continue to be protected by the Federal HIPAA privacy regulations.

I understand that health care providers may not condition the provision of treatment on the signing of this Authorization form; however, the Student's participation in certain School-sponsored activities may be conditioned on the signing of this authorization. As such, UHealth may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to: Practice Manager, UHealth Sports Medicine, 5555 Ponce de Leon Blvd, Coral Gables, FL 33146.

If the Student is under 18 years of age, this Authorization must be signed by a parent or legal guardian to be valid. If the Student is 18 years of age or older, the Student must sign this Authorization.

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Signature Date

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Print Name

Legal Authority (Circle one): Legal Guardian Parent of Minor Other