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**Vassar College Sports Medicine
Student-Athlete Authorization/Consent
for
Disclosure of Protected Health Information**

I, _____, hereby authorize Vassar College Athletics
(Name of Student-Athlete)

and it's Sports Medicine Department (physicians, athletic trainers and health care personnel) to disclose my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics to Baldwin Health Services and any referred physicians and their employees. I also authorize Baldwin Health Services and the referred physicians to disclose my protected health information and any related information regarding any injury or illness to Vassar College Sports Medicine Department personnel. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. I understand that if my record contains information concerning treatment for abuse, physical and/or mental illness or drug/alcohol treatment, such information will be released pursuant to this consent. This protected information may be released to other health care providers, parent/guardians, hospital and/or medical clinics and laboratories, athletic coaches, strength and conditioning coaches, medical insurance coordinators, insurance carriers, academic counselors, athletic and/or college administrators and sports information staff.

If the requested portion of the record contains information pertaining to the treatment for abuse, physical and/or mental illness or drug/alcohol treatment, or contains HIV/AIDS related information, you must specifically authorize the release of such information by **initializing** one or both of the following:

Initials

____ I understand that if my record contains **information concerning abuse, physical and/or mental illness or drug/alcohol treatment**, such information will be released pursuant to this consent.

____ I understand that if my record contains **confidential HIV/AIDS related information**, such information will be released pursuant to this authorization form. Confidential HIV/AIDS related information is any information indicating that a person had an HIV/AIDS related test, or has HIV infection, HIV related illness or AIDS, or any information which indicate that a person has been potentially exposed to HIV/AIDS.

I understand that my protected health information will be used by Baldwin Health Services and any of the above mentioned individuals/companies for the purpose of injury/illness notification and treatment, as well as, any other purpose deemed necessary by the staffs of the Vassar College Sports Medicine Department and Baldwin Health Services.

I understand that my signing of this authorization/consent is voluntary and that my institution will not condition any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for disclosure. I understand that my protected health information is protected by federal regulations under either the Health Insurance Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA or conference athletics but may affect my athletic eligibility at Vassar College.

I understand I have the right to revoke this authorization/consent at any time by sending written notification to the head athletic trainer at my institution. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent. I also understand that revocation of this authorization/consent may affect my athletic eligibility. This authorization/consent expires six (6) years from the date it is signed.

Printed Name of Student-Athlete

Signature of Student-Athlete

Date

Social Security Number

Date of Birth

Signature of Parent/Legal Guardian if Student-Athlete (if under 18 yo)

Date