

Emmanuel College Athletic Department

HIPPA Form

HIPAA stands for Health Insurance Portability and Accountability Act and was created to increase the privacy of individuals' personal health information. It affects all those who are in contact with medical records or personal health information. Under this law, certified athletic trainers (ATC's) will not be able to speak to anyone in regards to an injury or condition unless a release is signed.

By signing below I _____ (**print student athlete's name**) am allowing FULL disclosure of my personal health information and information in regards to any athletic injury I may sustain while participating in intercollegiate athletics at Emmanuel College. I also understand that I may revoke such permission at a later date, if I so desire.

Any athletic injury may be disclosed to the following, but not limited to, individuals/companies:

- Emmanuel College coaches
- Emmanuel College administration/student services
- Emmanuel College's insurance company
- Emmanuel College's team physician(s) and their office staff
- Athlete's personal insurance company
- Athlete's personal physician(s) and their office staff
- Athletic Trainers at opposing schools for treatment guidelines
- Legitimate Representative Professional Sports club, teams, or scouting organizations and all media outlets
- Parents of above student athlete

I hereby authorize Emmanuel College and its Secondary Insurers to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. Finally, I authorize Emmanuel College to transfer medical and insurance information to health care providers and facilities as needed to provide for care or treatment, which may be required for future or past injuries. A photostat copy of this authorization shall be deemed as effective and valid as the original. I understand that this information may have a bearing on my being offered employment, the opportunity for employment, or the type of offer or opportunity for employment from professional sports clubs, teams or organizations.

Athlete's signature: _____ Date: _____

Parent's Signature _____ Date: _____

(required if athlete is under 18)

Complete this section only if you are revoking your permission

I hereby revoke my permission for release of medical records given above. I understand that the professional sports team, club, organization, or media outlet will be told that I have denied the release of my medical records.

Athlete's signature: _____ Date: _____

Parent's Signature: _____ Date: _____

(required if athlete is under 18)