

## HIPAA AUTHORIZATION FORM

I hereby authorize Riverview Health Sports Medicine (Riverview Health) to disclose the personal health information of \_\_\_\_\_ (Student) as follows:

The personal health information (PHI) of the Student which may be disclosed under this Authorization includes records of physical examinations performed by Riverview Health to determine the Student's eligibility to participate in classroom or other School sponsored activities; records of the 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.

The PHI may be disclosed to the University High School (School) principal or assistant principal, athletic director, coach, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in School sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities. The PHI may also be disclosed to any other emergency medical personnel, hospital or other health care professional who evaluates, diagnoses or treats an injury, illness or other condition incurred by the Student while participating in these School sponsored activities. Lastly, the PHI may be disclosed to the School to document the sports medicine services provided by Riverview Health under contract.

I understand that Riverview Health has requested this authorization to disclose the PHI above so that the School, in conjunction with Riverview Health, can make certain decisions about the Student's health and ability to participate in certain classroom and School sponsored activities in accordance with the Health Information Portability and Accountability Act and its privacy and security regulations (HIPAA). The Student's participation in certain School sponsored activities is conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Riverview Health in reliance on this authorization, by sending a written revocation to the School principal (or designee).

**NOTE: 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 OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name and Relationship to Student (if Signed by Parent or Guardian)

**THE STUDENT SHALL NOT BE CLEARED TO PARTICPATE IN INTERSCHOLASTIC ATHLETICS UNTIL THIS AUTHORIZATION HAS BEEN SIGNED AND RETURNED TO THE SCHOOL.**