Authorization to Disclose Protected Health Information

Sports Medicine

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits disclosures of protected health information (PHI). PHI is any information, including demographics, whether oral, electronic, or paper, which is created or received by a health care provider and relates to your healthcare or payment for the provision of health care.

Mayo Clinic Health System Sports Medicine personnel (physicians, advanced care providers, athletic trainers, nurses, and physical therapists) are present at many athletic practices and events. In their role in ensuring the continuum of care for the student athletes, they may need to relate student athletes' PHI to coaches, game officials, athletic department personnel, and parents (authorization required for disclosure to parents, if student athlete is 18 years of age or older). Mayo Clinic Health System Sports Medicine requires this written authorization for the purpose of these disclosures.

I authorize Mayo Clinic Health System Sports Medicine personnel to verbally disclose to my coaches, athletic directors, game officials, athletic department and school personnel, and my parents, any of my PHI that may affect my participation status for interscholastic sports. This includes, but is not limited to, information about my past injuries or illnesses and injuries or illnesses that I may suffer during the recommended restrictions for those injuries or illnesses.

This authorization is valid for 12 months. I understand that I have the right to revoke this authorization in writing. Written revocation should be sent to Privacy Officer, Mayo Clinic Health System, Health Information Services. I understand that the revocation will not apply to information that has already been released prior to the written notification. I understand that Mayo Clinic Health System will not condition treatment on whether I sign this authorization. I understand that authorizing the discloser of this PHI is voluntary and I may refuse to sign this authorization. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. A copy of this authorization is as valid as the original.

Student Athlete's Name:____

Date of Birth:____

High School Name:____

Involved Sport(s):____

Student Athlete's Signature:____

Parent or Legal Representative:____
(parent must sign if athlete is under 18 years of age)

Date:____

White Copy – Medical Record Yellow Copy – Participant Pink Copy - School

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