

# The University of Tennessee at **CHATTANOOGA**

## **FERPA Authorization for Release of Health Information**

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Sport

\_\_\_\_\_  
Date of Birth

TO: THE UNIVERSITY OF TENNESSEE AT CHATTANOOGA ATHLETIC TRAINERS, PHYSICIANS,  
STRENGTH COACHES, SPORTS DIETICIANS AND OTHER RELATED PERSONNEL:

You are hereby authorized and requested to disclose information and records pertaining to my physical health or condition, whether past, present or future, including all physicals, physicians' records, athletic trainers' records, diagnoses, treatment information, histories, and prognoses, and including information and records pertaining to any and all injuries or illnesses to (i) the University of Tennessee at Chattanooga Department of Athletics and its personnel (including coaches of my sport) who the University, in good faith, determines have a legitimate "need to know;" (ii) UTC's team physicians; (iii) all media organizations, including print, television, radio and internet, but only disclosing such information to the media as it relates to my ability to participate in my sport; and (iv) my parent(s), step-parent(s) or legal guardian(s) but only after I have informed such person(s) of my particular injury or illness.

The purpose of this authorization is (i) to assist coaches and other personnel within the Department of Athletics in evaluating my fitness as it pertains to my ability to participate in my sport; (ii) to allow personnel within the Department of Athletics to assist me with respect to my athletic grant-in-aid or with respect to my academic progress; (iii) to assist UTC's team physicians in providing medical care to me; (iv) to meet the requirements of insurers or health plans when such insurers require such information before paying for your health care services; (v) to allow athletic training students and student physicians in training to participate in my medical care or to contribute to their educational training; (vi) to provide to the media, for redisclosure to their respective audiences, information regarding my fitness as it pertains to my ability to participate in my sport; and (vii) to inform my parent(s), step-parent(s) or legal guardian(s) of my injury or illness.

I hereby agree that the information that is used or disclosed pursuant to this Authorization may be redisclosed by the receiving entity. For example, information given to the media about my physical ability to play my sport will, in all likelihood, be redisclosed to their audience. By signing below, I specifically authorize and consent to all such redisclosures.

I understand that the information to be disclosed is protected either as "education records" by The Family Educational Rights and Privacy Act of 1974 or as "medical records" under Tennessee law and, with certain exceptions, may not be disclosed without my consent. By signing this form, I certify that I agree to the disclosure of the records referenced above.

A copy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
Student-Athlete Signature

\_\_\_\_\_  
Signature of Parent/Guardian if Student-Athlete is Under 18  
Years of Age

DATE: \_\_\_\_\_

DATE: \_\_\_\_\_