

The University of Tennessee at CHATTANOOGA

I. Authorization for Medical Information to be released to the University of Tennessee-Chattanooga

I, _____, age _____, while participating in the Intercollegiate Athletic Program, representing the University of Tennessee of Chattanooga, expressly authorize The University of Tennessee at Chattanooga Student Health Service, Memorial Hospital, and/or any other medical institution which might render medical treatment to me during this period, to release the said records to the University of Tennessee at Chattanooga Athletic Department, Head Athletic Trainer, Head Coach of the sport I am participating in, or its Insurance carrier, in order to better inform the related personnel of my medical condition, capabilities, and progress while I participate in the Intercollegiate Athletic Program at The University of Tennessee at Chattanooga. I understand this information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information.

I understand that my health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment). I understand that once information is disclosed with my consent/authorization, the information may be re-disclosed and may no longer be protected by previously stated law. I understand that I may revoke this authorization at any time by notifying the Head Athletic Trainer in writing, but it will not have any effect on actions the university or university athletic department took prior to the revocation. A photostatic copy of this authorization shall be considered as effective and valid as the original, **and will be valid for six years upon the date signed.**

(Signature of Athlete)

Date

(Sport)

(Social Security Number)