2020-21 GOSHEN PHYSICIANS HIPAA RELEASE FORM FOR:

Student Name: ___________________________ Grade: ____________

Use and Disclosure of Protected Health Information
to Persons Involved in the Students Care

Goshen Physicians
2004 Elkhart Road, Suite A
Goshen, IN 46526

FILL IN ONE OF THESE BOXES →→→→→→→→→→→→→

***(consent for student athletes _UNDER 18 YEARS OF AGE_)**

I __________________________ as the Parent, Guardian or Legal Representative of
(print parent/guardian name)

______________________*(print name of student)*______

Student-Athlete Birthdate ___/___/______

OR

***(consent for student athletes 18 YEARS OLD OR OLDER)**

I _________________________a student athlete participating in the school sports program
(Student-Athlete 18 or older print your name)

understand that I have the right to agree, restrict or object to the disclosure of Protected Health Information (PHI) by the Athletic Trainer to members of the school athletic department. This includes but is not limited to the Athletic Director, Coach and members of the coaching staff. I understand the information disclosed by this authorization may be subject of re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

By my signature, I give the Athletic Trainer permission to disclose PHI to members of the school's athletic department. I understand that the information disclosed will be limited to the injury/illness affecting athletic participation. I understand that I can revoke this permission to disclose at any time by submitting such request to the Athletic Trainer in writing. The revocation of permission will apply from the date of receipt and is not retroactive.

This permission is in effect for the athletic period: **June 1, 2020 through June 30, 2021**

(COMPLETE _ONLY For Student-Athletes 18 years and older_)
I agree to permit the Athletic Trainer to share the above granted information with my parents and/or individual(s) I so designate Yes____ No____ Initials:___________ONLY FILL IN FOR STUDENT-ATHLETES 18 OR OLDER

Additional individuals who may receive PHI:

____ ____

Parent Signature: ______________________________________*(Student-Athlete should sign only if 18 or older)*

Date:______________________

Authority to sign if not parent:____
(Guardian or Legal Representative)