Strom Thurmond High School

Student-Athlete HIPAA Authorization Form

Patient's Name:_____ Date of Birth:_____

I understand my rights under the federal regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA). I authorize Strom Thurmond High School Sports Medicine Program (including athletic trainers, athletic training students, and student interns) to provide to my parents or guardians, coaches, and medical personnel all information concerning my health care, injury, rehabilitation, treatment, and health status. This information is to be used for the following purposes: advising persons of my health or injury status for further medical treatment; accessing the insurance coverage under the policy that covers medical treatment and costs for me; and advising the coaching staff of my health status and restrictions on my ability to participate in athletics.

It is important this form is signed by the student-athlete or legal guardian. It affects the documentation and communication forms which are used in the athletic training room with team physicians, coaches, and support staff. The signature authorizes the members of the Sports Medicine Program, team physicians and allied health care providers to communicate and view medical records pertaining to health-related issues of the student-athletes. The methods of injury documentation and communication used will be:

- Oral and written communication regarding health issues between the athletic trainer, the team physician and medical support staff
- Oral and written communication regarding health issues between the athletic trainer and coaching staff
- Oral and written communication regarding health issues between the athletic trainer and the athlete's parents, per athlete's request
- Oral and written communications regarding health issues between the athletic trainer and academic services staff, faculty, and school nurse if the injury/illness impacts your ability to attend class and/or fulfill other academic obligations
- Oral and written communication regarding health issues between the athletic trainer and Georgia Regents Sports Medicine department in regards to scheduling appointments and appointment follow ups
- Written documentation regarding injuries and injury treatments (i.e. Daily Treatment Logs and Injury Reports)

I understand that I may revoke this authorization in writing at any time by notifying, in writing, the Athletic Director. Revoking my authorization will not have any effect on the actions Strom Thurmond High School took in reliance on this authorization prior to receiving the revocation. This authorization expires one year from the date it is signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information Management Services at (706) 721-2722.

Print Name _____ Sport(s)_____

Signature of Student-Athlete _____ Date of Signature_____

Signature of Parent/Legal Guardian (if student athlete is under 18 years of age)
_____Date of Signature_____

Setting Appointments

As part of the partnership of our athletic department and Georgia Regents Sports Medicine, the athletic trainer can set up appointments with the Sports Medicine Doctors and get the athlete in to see the Doctor much quicker than if they were to set up their own appointment. In order for the athletic trainer to do this, he or she needs the following information to get the athlete in the computer system at Georgia Regents. Please fill out this information if you would like this option to be a possibility for your athlete in the event they are injured and need to see a Doctor.

Athlete's Information

Name: _____ DOB:_____ Gender:_____

Phone Number: _____ Address:_____

Race:_____ Primary Language:_____

Insurance Guarantor's Information

Name: _____ DOB:_____

Relationship to athlete:_____

Phone Number: _____ Address:_____

Insurance Company:_____

Insurance Policy and or Group #:_____

Emergency Contact Information

Name: _____

Relationship to Athlete:_____

Emergency Contact Phone:_____

Emergency Contact Address:_____