Student-Athlete Authorization/Consent for
Disclosure of Protected Health Information for
NCAA-Related Research Purposes

I. ____________________________ hereby authorize ____________________________
   Name of Student-Athlete                                Name of my Institution

and its physicians, athletic trainers and health care personnel to disclose my protected health
information including, without limitation, any information regarding any injury, illness, treatment or
participation related to or affecting my training for and participation in intercollegiate athletics to the
NCAA, and its designated employees, agents and/or contractors. I further authorize the NCAA to
disclose, and/or use, such information as provided herein.

I understand that my participation and protected health information may be disclosed to, and/or used
by, the NCAA and authorized third parties to receive such information for the purpose of using injury,
relevant illness and participation information collected from multiple student-athletes and institutions
in a manner that does not identify myself or my school. The information is provided to NCAA
committees, athletics conferences and individual schools, and NCAA-approved researchers to evaluate
the effectiveness of health and safety rules and policy, and to study other sports medicine questions.
Selected de-identified summary (aggregate) data also are made accessible to the general public as a
service to further the general understanding of athletic injury patterns and help develop education on
student-athlete health topics.

I am making this authorization/consent voluntarily to release my health information otherwise
protected by federal regulations under either the Health Insurance Portability and Accountability Act
of 1996 (HIPAA) or the Family Educational Rights and Privacy Act of 1984 (Buckley Amendment).
The NCAA and institution are not requiring this authorization/consent to be signed.

I understand that while HIPAA regulations may not apply to NCAA use or disclosure of my
injury/illness information, the NCAA is committed to protecting my privacy. I understand that my
data will be stored securely within industry standards.

This authorization/consent for transfer of protected health information expires 545 days from the date
of my signature below, but I have the right to revoke it in writing at any time by sending written
notification to the director of athletics at my institution. I understand that a revocation takes effect on
its request date and does not affect any action taken prior to that date.

____________________________________  ______________________________________
Printed Name of Student-Athlete                      Signature                                      Date

If a student-athlete is under 18 years of age, parent/legal guardian is also required to sign this form.

____________________________________  ______________________________________
Printed Name of Parent/Legal Guardian                Signature                                      Date