

**Stevens Institute of Technology**  
**Department of Physical Education, Athletics, and Recreation**  
**Student-Athlete Authorization/Consent for Disclosure of**  
**Protected Health Information**

\_\_\_\_\_ I hereby authorize the physicians, athletic trainers, sports medicine staff and other healthcare professionals representing Stevens Institute of Technology and the Stevens Institute of Technology Department of Physical Education, Athletics, and Recreation to release information regarding my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. I understand that if my record contains information containing treatment for abuse physical and/or mental or drug/alcohol treatment, such information will be released pursuant to this consent. This protected health information may be released pursuant to this consent. This protected health information may be released to other health care providers, parents/guardians, hospital and/or medical clinics and laboratories, athletic coaches, strength and conditioning coaches, medical insurance coordinators, insurance carriers, medical supply vendors and/or service companies, academic counselors, athletic and/or university administrators, chaplains and/or clergy members, NCAA Injury Surveillance System, sports information staff and members of the media.

If the requested portion of the record contains information pertaining to the treatment for abuse, physical and/or mental illness, drug or alcohol treatment or contains HIV related information, you must specifically authorize the release of such information by initialing the following:

\_\_\_\_\_ I understand that if my record contains **information concerning treatment for abuse, physical and/or mental or drug/alcohol treatment**, such information will be released pursuant to this consent.

\_\_\_\_\_ I understand that if my record contains **confidential HIV related information**, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

I understand that my authorization/consent for the disclosure of my protected health information is a condition for participation as an intercollegiate student athlete for Stevens Institute of Technology. I understand that my protected health information is protected by federal regulations under either the Health Insurance Portability and Accountability Act(HIPAA) or the Family Educational Rights and Privacy Act of 1974(Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that once this information is disclosed per my authorization/consent, the information is subject to redisclosure and may no longer be protected by HIPAA and/or the Buckley Amendment.

I understand that I may revoke this authorization/consent at any time by notifying in writing the Head Athletic Trainer, but if I do, it will not have any effect on the actions Stevens Institute of Technology and the Department of Athletics took in reliance on this authorization/consent prior to receiving this revocation. I also understood that revocation of this authorization/consent may affect my athletic eligibility. This authorization/consent expires six (6) years from the date it is signed.

\_\_\_\_\_  
Name of Student Athlete

\_\_\_\_\_  
Signature of Student Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

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

\_\_\_\_\_  
Signature of Parent/Legal Guardian(if under 18)

\_\_\_\_\_  
Date