COCHISE COLLEGE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby release my pertinent medical information to the following:

- Other Athletic Training Staff Members
- Physicians, related to my personal care
- Coaches and other Athletic Staff
- Parents/Legal Guardians/Spouse
- Teammates
- Cochise College Sports Information Media
- Professional teams and Other Colleges and their representatives, after a waiver has been signed for that particular requests
- the NJCAA
- Other CC Administration (as deemed necessary)
- Insurance Company and Agents

I hereby authorize all members of the Cochise Athletic Training Staff and any physicians or health care professionals retained by them to release necessary information, records, and reports regarding my medical history, medical status, record of injury and/or surgery, prognosis, diagnosis, record of serious illness, rehabilitation, and related personally identifiable health information to parties identified above. The information includes injuries or illnesses relevant to past, present, or future participation in athletics at Cochise College.

I understand that if the information being disclosed herein may contain information regarding alcohol/drug abuse or treatment, psychiatric care, sexually transmitted diseases, AIDS or HIV, or Hepatitis B or C testing or results, I agree to their release.

The reason for this disclosure is to advise the parties identified above of the nature, diagnosis, prognosis, or other treatment concerning my medical condition and injuries/illnesses sustained while I am a student-athlete. I understand that the individuals or entities receiving the information may not be health care providers covered by federal privacy regulations, and that the information described above may be disclosed publicly.

I understand that my authorization/consent for the disclosure of my protected health information is a condition for participation as an intercollegiate athlete for Cochise College. I understand that my protected 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 or 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. In understand that once 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 Cochise College will not receive compensation for its use/disclosure of the information. I may inspect or copy any information used/disclosed under this authorization. I understand that I may revoke this authorization at any time by notifying in writing to the Head Athletic Trainer, but if I do, it will not have any effect on actions the university took in reliance on this authorization prior to receiving the revocation. This authorization expires six (6) years from the date it is signed.

Athlete Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Cochise College Athletic Department
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