



AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION NEEDED TO ASSIST IN THE DETERMINATION OF THE STATUS OF A CLAIM FILED AGAINST THE STUDENT ACCIDENT INSURANCE POLICY

I hereby authorize the *use and disclosure of Protected Health Information* to the individual(s) indicated below:

Information to used or disclosed May Include:

- | | |
|---|---|
| <input checked="" type="checkbox"/> Provider name, address & specialty (required) | <input checked="" type="checkbox"/> Medical diagnosis |
| <input checked="" type="checkbox"/> Dates of service (required) | <input checked="" type="checkbox"/> Services rendered |
| <input checked="" type="checkbox"/> Cost of services (required) | <input checked="" type="checkbox"/> Medications |
| <input checked="" type="checkbox"/> Physicals | <input checked="" type="checkbox"/> General Medical History |

Persons or class of Persons to Whom the Disclosure May Be Made:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Certified Athletic Trainers | <input checked="" type="checkbox"/> Coaches |
| <input checked="" type="checkbox"/> Doctors | <input type="checkbox"/> Media |
| <input checked="" type="checkbox"/> Student Health Center Staff | <input type="checkbox"/> Dean of PE/Athletic |
| <input checked="" type="checkbox"/> Insurance Companies | <input type="checkbox"/> Parent |

I understand that this Authorization relates to individually identifiable health information about me, which is called *Protected Health Information* as defined by the *Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)*; and,

that if the person or entity that receives this information is not a health plan, health care clearinghouse, or health care provider as defined in the *Privacy Rule*, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law; and,

that I may revoke the authorization at any time by notifying the COC Athletic Training Staff *in writing*. However, if I chose to do so, my revocation will not affect any actions taken *prior* to my revocation; and,

that I may refuse to sign this authorization and that my refusal to sign in no way affects my sport participation. My refusal, however, *may* affect payment and *may* delay the processing of my claim.

Insured Student's Name (print) _____

ID or Social Security Number: ____ - ____ - ____

Date of Birth: ____/____/____

Claimant is: Self

Athlete's Signature _____

Date: ____/____/____

Minor (check if under 18)

Parent/Legal Guardian's Signature (if a minor) _____

Date: ____/____/____