



Authorization to Disclose Protected Health Information

Background Information. The Stanford Sports Medicine Program is the athletic trainers, physical therapists, physicians, and other health care providers to whom student athletes are referred and who are responsible for the health care of Stanford's student athletes. It adheres to federal and state laws governing the privacy of your health information. Specifically, the Sports Medicine Program complies with the federal privacy regulations issued under the Health Insurance Portability and Accountability Act of 1966 (HIPAA), which identifies certain information as "protected health information" (PHI). HIPAA provides you with certain rights and the Sports Medicine Program with certain obligations when dealing with your PHI. You are being provided with a Notice of Privacy Practices that describes in greater detail these rights and obligations.

As a member of an athletic team at Stanford University, many people may have an interest in your health, including your coaches, administrators, scholarship donors, alumni, scouts, media, etc. These people are not entitled to your PHI unless you specifically choose to share it.

The attached authorization permits you to decide under what circumstances you will allow the Stanford Sports Medicine Program to disclosure of your PHI. For example, you may wish to allow the Stanford Sports Medicine Program to provide the information necessary to your coach and Department of Athletics administrative staff so they may appropriately modify your participation in sport-related activities to protect your health.

When you give your authorization to disclose PHI, the disclosure is limited to the minimum information necessary for the purpose you have authorized. It would also include all relevant information contained in your medical records, including your medical history and test results.

FERPA. If the coaches and administrative staff of the Department of Athletics receive any of your medical information, they may have obligations under the Federal Education Record Privacy Act (FERPA) to treat it as confidential as an educational record. A Notice of Privacy Practices related to FERPA is printed in your student bulletin. The coaches and administrative staff will also ask you to complete another form to indicate what PHI, if any, they may disclose to others such as your family or the media.

Instructions For Attached Authorization Form. The following forms provides certain commonly encountered circumstances in which you may want to authorize disclosure of your PHI. If you grant authorization to disclose PHI in these circumstances, please check the appropriate boxes. You may withdraw your authorization at any time as explained in the form. You may also at any time amend this form or complete and submit another form to provide authorization of disclosures which you do have not granted. If you do not wish to authorize any disclosure of PHI, then you only need to complete the final signature section at the end of the form.

PHI could include sensitive information such as alcohol and drug use, dependence, and treatment; sexually transmitted diseases; disordered eating behaviors; and psychological and psychiatric evaluations and treatment. PHI could also include non-athletic conditions; pre-existing and new conditions detected on your pre-participation evaluation; previous injuries and illnesses and their treatment; radiology and lab test results; specialist reports. In making your choices, please remember that only the minimum necessary PHI will be disclosed. None of this sensitive information would necessarily be disclosed, for example, unless it was necessary to evaluate your ability to participate safely in the training, practice, and competition for your sport.



Authorization to Disclose Protected Health Information *** Sports Medicine Program ***

Student-Athlete Name _____ Phone Number _____

Medical Record Number _____ Date of Birth _____

Address: _____ Intercollegiate Sport(s) Participating in: _____

Authorization to Disclose PHI to Coaches and Department of Athletics Administrative Staff

I authorize Stanford Sports Medicine to disclose the minimum PHI necessary to my coaches and related administration staff to evaluate my ability to participate safely in the training, practice and competition for my sport. This includes the essential information required to explain limitations in my participation in conditioning, weight training, practice or competition in order to protect myself from further risk of injury or illness and to facilitate communication with coaching staff for the purpose of modifying my participation. This may include disclosure of my medical history, my Pre-Participation Evaluation, my physical examination results, as well as identification of the diagnosis of any conditions, recommended activity restrictions, treatments, medical interventions, compliance with treatment protocols, and progress reports necessary for me to train, practice or compete safely in my sport. I understand that if I decline to make this authorization that it could result in the coaching or administrative staff having insufficient information to make the best decision regarding my practice and playing schedule given my medical condition.

- Authorization granted for relevant coaching staff and Department of Athletics administrative staff
- Authorization denied for both coaching and Department of Athletics administrative staff.

Authorization to Disclose PHI to Family Members

I authorize Stanford Sports Medicine Program to disclose the minimum PHI (e.g., diagnosis, recommended treatments, progress reports) necessary to my family members in order to allow my family members to assist me in making medical decisions concerning any injury or other medical condition while I am under the care of Stanford Sports Medicine Program.

- Authorization granted to inform family members
- I specifically prohibit the disclosure of the following PHI to my family members. (Please specify restrictions on authorized disclosures, if any):

- Do not disclose my PHI to any of my family members.

Disclosure of Protected Health Information to Other Individuals

I authorize Stanford Sports Medicine to disclose the minimum PHI necessary to the individuals or entities specified below.

Specify to whom the information is to be disclosed:

Specify the medical information to be disclosed:

Specify the purpose for the disclosure:

If initiated by you, simply check the following box: at the request of the individual. If initiated by others, specify the purpose: _____

Revocation or Modification. You may revoke or modify this authorization in writing at any time, by amending this form or providing a written revocation or completing another authorization form and restricting or electing no disclosure, at the following address:

*Charlene Dow
Stanford Sports Medicine Center
341 Galvez Street
Stanford University
Stanford, CA 94305-6175
650-725-8202 (O)*

Signatures. I understand that: (a) if the authorized recipient of this information is not legally required to keep the information confidential, the recipient may disclosure it to others; (b) I may refuse to sign this authorization and any refusal will not effect my ability to obtain treatment from the Stanford Sports Medicine Program; and (c) I am entitled to a copy of this completed and signed authorization form.

This authorization expires one year plus 30 days from the date I sign below.

I elect to authorize disclosure of my PHI as specified above.

Signature of Student-Athlete (Patient)

Date

OR

I elect **NOT** to authorize disclosure of **ANY** of my PHI at this time.

Signature of Student-Athlete (Patient)

Date