Clarendon College Athletics
HIPPA Release Authorization

Not withstanding the recent federal regulations concerning privacy with respect to medical records. And while interpretation still exists regarding "covered entities" as it relates to these matters, the following represents a release of authorization for sharing medical information by Clarendon College Athletic Department.

By signing below, I understand the following conditions:

A. The authorization covers information about injury and illness that might incur during the course of the academic year.
B. The authorization is valid for one year only and will conclude at the end of the academic year unless the specific situation remains unresolved.
C. The authorization covers only those directly involved with my athletic participation including primary care physicians, team physicians, consulting physicians, emergency room physicians, athletic trainers, physical therapists, coaches, strength & conditioning staff and any others directly involved with issues affecting my general fitness to participate in intercollegiate athletics.

The above information will be given to only those directly involved in the care and treatment of any specific condition, to those responsible for rehabilitation or athletic related fitness and conditioning programs or to those responsible for decisions regarding actual participation in practice or game situation.

Any athlete has the right to revoke this authorization and by doing so cannot and will not be denied any required medical care. Participation in intercollegiate athletics is contingent upon the completion of this authorization however so choosing to revoke this authorization is a choice not to play.

By signing below, I attest that I have read the above statement, understand its intent, and grant release authority as outlined within.

Name:_____ Sport:_____

Signature:_____

Date: ____/_____/_____