



Student-Athlete Authorization/Consent for Disclosure of Protected Health Information for NCAA-Related Research Purposes

I, _____ hereby authorize _____
Name of Student-Athlete Name of my Institution

and its physicians, athletic trainers and health care personnel to disclose my protected health information including, without limitation, any information regarding any injury, illness, treatment or participation related to or affecting my training for and participation in intercollegiate athletics to the NCAA, and its designated employees, agents and/or contractors. I further authorize the NCAA to disclose, and/or use, such information as provided herein.

I understand that my participation and protected health information may be disclosed to, and/or used by, the NCAA and authorized third parties to receive such information for the purpose of using injury, relevant illness and participation information collected from multiple student-athletes and institutions in a manner that does not identify myself or my school. The information is provided to NCAA committees, athletics conferences and individual schools, and NCAA-approved researchers to evaluate the effectiveness of health and safety rules and policy, and to study other sports medicine questions. Selected de-identified summary (aggregate) data also are made accessible to the general public as a service to further the general understanding of athletic injury patterns and help develop education on student-athlete health topics.

I am making this authorization/consent voluntarily to release my health information otherwise protected by federal regulations under either the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the Family Educational Rights and Privacy Act of 1984 (Buckley Amendment). The NCAA and institution are not requiring this authorization/consent to be signed.

I understand that while HIPAA regulations may not apply to NCAA use or disclosure of my injury/illness information, the NCAA is committed to protecting my privacy. I understand that my data will be stored securely within industry standards.

This authorization/consent for transfer of protected health information expires 545 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the director of athletics at my institution. I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

Printed Name of Student-Athlete

Signature Date

If a student-athlete is under 18 years of age, parent/legal guardian is also required to sign this form.

Printed Name of Parent/Legal Guardian

Signature Date