**Health Insurance Portability and Accountability Act**

**(HIPAA) Consent Form**

My treating physician and /or other treating authorities such as Stonewall

Jackson Hospital or Augusta Medical Center are authorized to disclose

information regarding any injuries I might receive during the course of the

season as well as my general fitness to play to my athletic trainer, who is

then authorized to disclose this information to my head coach/Administration.

Once the health information is disclosed to a non-covered entity such as a

head coach, it may no longer be protected under HIPAA.

The student/athlete has the right to refuse to sign this consent form, and in

doing so, he/she will not be denied treatment based on this refusal. The

student /athlete also has the right to withdraw his/her consent; this

withdrawal must be done in writing.

This form is in effect from May 1 of the current year through June 30 of the

succeeding year.

**Signature of Student/Athlete Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Parent/Guardian Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Return to Head Coach**