

**PACIFIC UNIVERSITY ATHLETIC TRAINING DEPARTMENT
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

I understand that the Pacific University Athletic Training Department may need to use and disclose my health information for purposes of treatment, health care operations or other reasons permitted by law.

I understand that my health information may include information both created and received by the Department, may be in the form of written, electronic or verbal communication and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health related information.

Part 1. Individual's information

Name:		Date of Birth:	
Address:		City:	
State:	Zip:	Phone #:	

Part 2. Information about the use or disclosure

I, the undersigned, understand and agree that Pacific University Athletic Training Department may use and disclose my health information to the Athletic Director, Associate Athletic Director, Athletic Training Staff, Coaches and Sports Information Director in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, and coordinate with other health care providers for my care and treatment.
- Determine my eligibility for health insurance benefits or coverage.
- Release information to the media when a condition or injury affects your ability to participate.
- Perform office or administrative functions that support the Department's effort to provide me with effective health care.
- Facilitate any other reason permitted by law.

Part 3. Important information about your rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the Pacific University Athletic Training Department in writing, but the revocation will not have any affect on any actions taken before the revocation was received.
- I understand that if I choose not to sign this authorization I may be refused clearance to participate for safety reasons.
- I may see and copy the information described on this form if I ask for it.
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

Part 4. Signature

I hereby authorize the Pacific University Athletic Training Department to use or disclose my health information as described in Part 2.

Signature of Patient:	Date:
Patient Representative(printed name):	Date:
Signature of Patient Representative:	Representative's Relationship to individual: