

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION NEEDED TO ASSIST IN THE DETERMINATION OF THE STATUS OF A CLAIM FILED AGAINST THE STUDENT ACCIDENT INSURANCE POLICY

I hereby authorize the *use and disclosure of* **Protected Health Information** to the individual(s) indicated below:

Information to used or disclosed May Include:	
[x] Provider name, address & specialty (required) [x] Dates of service (required) [x] Cost of services (required) [x] Physicals	[x] Medical diagnosis[x] Services rendered[x] Medications[x] General Medical History
Persons or class of Persons to Whom the Disclosure May Be Made:	
[x] Certified Athletic Trainers [x] Doctors [x] Student Health Center Staff [x] Insurance Companies [x] Student Athletic Trainers I understand that this Authorization relates to individually which is called <i>Protected Health Information</i> as defined Insurance Portability and Accountability Act of 1996 (HIF	by the <i>Privacy Rule of the Health</i>
that if the person or entity that receives this information is not a health plan, health care clearinghouse, or health care provider as defined in the <i>Privacy Rule</i> , the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law; and,	
that I may revoke the authorization at any time by notifying the CWC Athletic Training Staff in writing. However, if I chose to do so, my revocation will not affect any actions taken prior to my revocation; and,	
that I may refuse to sign this authorization and that my refusal to sign in no way affects my sport participation. My refusal, however, <i>may</i> affect payment and <i>may</i> delay the processing of my claim.	
Insured Student's Name (print)	
ID :	Date of Birth://
Claimant is: [x] Self	
Athlete's Signature	Date://
[] Minor (check if under 18)	
Parent/Legal Guardian's Signature (if a minor)	Date://