STEELE MEMORIAL MEDICAL CENTER

P.O. BOX 700 ~ SALMON, ID 83467 ~ (208)756-5600 ~ FAX (208) 756-4169

Department of Sports Medicine
Student-Athlete Authorization/Consent for Disclosure of
Protected Health Information

I, ____________________________, hereby authorize physicians, sports medicine staff, and other healthcare professionals representing Steele Memorial Medical Center to release information regarding my protected health information and any related information regarding any injury or illness during my training for and participation in school athletics. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be released pursuant to this consent. This protected health information may be released to other healthcare providers, parents/guardians, hospital and/or medical clinics and laboratories, insurance carriers, and medical supply vendors.

I understand that my protected health information is protected by federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) and may not be disclosed without my authorization under HIPAA.

I understand that I may revoke this authorization/consent at any time by notifying in writing Steele Memorial Medical Center's Licensed Athletic Trainer (LAT).

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Name of Student Athlete	Signature of Student Athlete	Date

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Date of Birth

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Signature of Parent/Legal Guardian	Date