Michigan Stars FC
Sports Medicine Department
Authorization for Disclosure of Protected Health information

Athlete Name: ________________________Level:___________________ Date of Birth:______________

Address:________________________City:_______________State:_____________Zip Code:__________

I hereby authorize the physicians, athletic trainers, sports medicine staff and all other health care personnel representing Michigan Stars and the athletic department to release information regarding my protected health information and any related information regarding any injury or illness during my participation. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, participation status, and related personally identifiable health information. This protected health information may be released to:

_____All of the following parties may receive my protected health information:

OR (Please check all appropriate boxes in which protected health information MAY be released)

- o Health Care Providers
- o Parent/Guardians
- o Hospitals/Clinics
- o Insurance Carriers
- o Members of the Media
- o Coaches
- o Strength and Conditioning Coaches
- o Medical Insurance Coordinators
- o Sports Information Staff
- o Other: ________________________

I understand that my protected health information is protected by federal regulations under the Health Information Portability and Accountability Act (HIPPA) and may not be disclosed without either my authorization under HIPPA. I understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPPA. I understand that I may revoke this effect on actions the Michigan Stars FC or the athletic department took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent shall expire upon end of season or departure of the club; unless new form is completed and signed.

I understand that my authorization/consent for the disclosure of my protected health information is a condition for participation as a athlete at Michigan Stars FC. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Athlete's Name:____ Date: _____________________
Athlete's Signature:____

Parent/Guardian's Name:____Date:_______________________
Parent/Guardian's Signature:____
(If athlete is under 18 years of age)