



Michigan Stars FC

Sports Medicine Department

Authorization for Release 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 the Michigan Stars FC and the Michigan Stars FC athletic department to receive my protected health information for diagnosis and/or treatment purposes for professional athletic participation. I understand that my authorization/consent releases the following information: **(Please check one of the following)**

- Complete Medical Records
- Records concerning the following injury/illness _____
- Records for the period between ____/____/____ to ____/____/____
- Records are confined to the following information: **(please check all that apply):**
 - Medication Condition
 - Medical Status
 - Prognosis
 - Consultation
 - Operative Notes
 - Discharge Summary
 - Lab Reports
 - EKG/echocardiogram
 - Medications
 - History and Physical
 - X-ray Report
 - MRI/Ct Report
 - Progress Notes
 - Pathology Reports
 - Other: _____

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