

OLIVET NAZARENE UNIVERSITY
RELEASE OF ATHLETIC HEALTHCARE INFORMATION

I, _____ (print name), hereby grant permission and request that the Olivet Nazarene University Athletic Training Department release and discuss what they deem necessary for my safety, any information relating to my health care to the coaching staff, athletic administration, sports information office, and parents/guardians. This shall include injury/illness evaluation and diagnosis, treatment/rehabilitation plans and progress, availability and extent of my athletic participation and information related to referrals and possible surgical interventions. I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPPA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPPA or my consent under the Buckley Amendment. I understand that my signing of this authorization/release is voluntary and that my institution will not condition any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NAIA or conference athletics.

I, also permit the medical providers for Olivet Nazarene University Athletic Department, Olivet Nazarene University Student Health Services, Allied Health Professionals and the Athletic Training Department to discuss all aspects of my injuries/illnesses with each other, as they deem necessary for my safety and health care as well as to share all medical documentations. Documentation can include but not limited to medical notes, diagnostic and radiological test results and operative notes. Communications shall include injury/illness evaluation and diagnosis, treatment/rehabilitation plans and progress, availability and extent of my athletic participation and information related to referrals and possible surgical interventions.

This release remains valid for 380 days unless revoked by me in writing.

Printed Name: _____ Sport: _____
Signature: _____ Date: ____/____/____

I, _____ (print name), hereby grant permission and request that the Orthopedic Associates of Kankakee release and send copies of my medical records to the Olivet Nazarene University Athletic Training Department. This shall include, but not be limited to, physician notes/records, diagnostic test reports, physical and insurance information, referrals, and other medical information deemed necessary. This release remains valid until revoked by me in writing.

Athlete Signature: _____ Date: ____/____/____