

Youngstown State University
Athletic Training Room

MEDICAL CONSENT/RELEASE OF INFORMATION

Name: _____ Sport: _____

I hereby authorize the Youngstown State University medical staff and team physicians to administer medical treatment, emergency care, and/or surgical procedures and rehabilitation/reconditioning that may become necessary due to my participation in athletics.

This authorization is deemed valid for situations that may occur during athletics practices, weight training conditioning, competition, and travel.

I authorize the release of my medical records, medical status, including any related information in regard to any injury or illness that occurred in my past, present, or future participation in intercollegiate athletics at Youngstown State University to the athletic training staff, team physicians, health care personnel, coaches, and other members of the athletic department.

I understand that my protected health information can be used by the NCAA, Conference, media, and/or professional sports and their respective employees or agents for providing information to the public about my health status and care and probable return date to active sport participation.

I also understand that the NCAA, Conference, media, and professional teams may not be covered by the Buckley Amendment or HIPAA and that these regulations may not apply to their use or disclosure of my injury/illness information.

I understand that this form is voluntary and does not affect my participation in intercollegiate athletics.

This consent shall remain in effect for the entire period of my athletic eligibility, and may be revoked by written request at any time.

Signature

Date: _____

Social Security Number

I do not give my consent to release my protected medical information.