

MARIAN UNIVERSITY

Indianapolis

STUDENT ATHLETE HIPAA AUTHORIZATION FORM

I understand my rights under the federal regulations mandated by the Health Insurance Portability and Accounting Act (HIPAA) and I authorize Marian University's athletic training staff to provide to my parents or guardians, coaches, insurance company representatives, university personnel, and medical personnel, all information concerning my healthcare, injury, rehabilitation, treatment, and health status. This information is to be used for the following purposes: advising persons of my health or injury status for further medical treatment; accessing the insurance coverage under the policy that covers medical treatment and costs for me; and advising the coaching staff of my health status and restrictions on my ability to participate in athletics.

I do hereby consent to receiving athletic training services from St. Vincent Sports Performance. I understand that during the course of these services certain health information related to the student's athletic training services may be used and/or disclosed for treatment, payment or healthcare operations purposes, or as otherwise required by law. I further consent to certain health information being disclosed to school personnel, including but not limited to, coaches, school administration, and/or staff, as necessary.

I understand this consent is subject to my revocation at any time, except to the extent that action has been taken in reliance on this consent. Otherwise, this consent shall expire at the end of the school year or the student's current athletic season, whichever is later.

Student-Athlete Signature

Date



*St. Vincent
Sports Performance*



**STUDENT ATHLETE ASSUMPTION OF RISK AND
CONSENT FOR TREATMENT FORM**

Assumption of Risk

I understand the risk of injury or losses that can occur as a result of my participation in Intercollegiate Athletics and assume all such risks. In consideration of my being permitted to participate in the Marian University Intercollegiate Athletic Program, I release and agree to indemnify and hold harmless Marian University, its board of trustees, president, officers, students and employees from all claims, actions, damages and liabilities for personal injury or damage I might experience relating to or arising out of any Intercollegiate Athletics activity.

Consent for Treatment

I hereby further consent to Marian University obtaining whatever medical treatment and/or care as is deemed necessary by university staff for my health and well being as a Student Athlete and I hereby consent to have administered any emergency medical or surgical treatment recommended by a licensed professional.

Student-Athlete Signature

Date



*St. Vincent
Sports Performance*

PARENTS/GUARDIANS TO COMPLETE AND RETURN TO:

ATTN: ATHLETIC DEPARTMENT
MARIAN UNIVERSITY
3200 COLD SPRING ROAD
INDIANAPOLIS, IN 46222

FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS. NOTE: Complete all blanks. If information is not applicable, indicate the reason it is not, i.e., deceased, divorced, unknown.

Name of Athlete: _____ Sport: _____

Social Security Number: _____ Date of Birth: _____

College Address: _____ Phone: (____) _____

Home Address: _____ Phone: (____) _____

City: _____ State: _____ Zip: _____

Father/Guardian: _____ Mother/Guardian: _____

Social Security Number: _____ Social Security Number: _____

Address: _____ Address: _____

Employer: _____ Employer: _____

Address: _____ Address: _____

Phone: (____) _____ Phone: (____) _____

Medical Insurance Co.: _____ Medical Insurance Co.: _____

Address: _____ Address: _____

Policy Number: _____ Policy Number: _____

Phone: (____) _____ Phone Number: (____) _____

Is the company or plan listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO)? Yes _____ No _____

Does your insurance or plan require a second opinion before surgery? Yes _____ No _____

I hereby authorize **Marian University** and Student Athletic Protection, Inc. of Kalamazoo, MI to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and /or previous confinements and/or disabilities. **A photo static copy of this authorization shall be deemed as effective and valid as the original and valid up to two years from the date of signature.**

We authorize **Marian University** or its insurance agent to pay the medical vendors directly for any bills incurred from intercollegiate athletic accidents.

Student's Signature _____ **Date** _____

Parent's Signature _____