

**HUTCHINSON COMMUNITY COLLEGE  
AND AREA VOCATIONAL SCHOOL**

**CONSENT TO  
RELEASE OF PROTECTED HEALTH INFORMATION**

*In accordance with the standards of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), the following provides for the release of medical information to the appropriate listed personnel.*

I hereby authorize Hutchinson Community College (“HCC”) and its designees to use and/or disclose protected health information concerning my physical or medical condition, injuries or illnesses relating to my participation in intercollegiate athletics, past, present, or future, at HCC.

I hereby authorize any physician, physician assistant, athletic trainer, medical technician, nurse health care personnel who have treated me or assisted in my treatment for any injury, illness or physical or medical condition to disclose to HCC and its designees protected health information in connection with my participation in intercollegiate athletics at HCC.

This Release of Information is valid for one year from the date the release is signed. I understand that my authorization/consent for disclosure of my protected health information is a condition for participation as an intercollegiate athlete at HCC.

Important: Your Rights. I understand my rights, as described herein:

- I may revoke this authorization at any time by notifying the HCC Athletic Director in writing. My letter must be hand-delivered or mailed to HCC.
- A revocation will not affect any uses or disclosures that HCC made before it received my revocation.
- The information that is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPPA. I have the right to seek assurances from the above-named entities or individuals authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.
- If I execute this authorization form, I will receive a copy of it.
- Requests for Protected Health Information from various media outlets, and professional team personnel (i.e. scouts) are non-routine uses and authorizations for such disclosures by covered entities will be required before the Protected Health Information can be disclosed.

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Date

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Signature

Signature may be that of  
Athlete 18 years of age.  
If under 18, signature of  
Parent or guardian is  
Required.

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Parent or Guardian

I hereby grant permission on behalf of my minor son or daughter or my ward.

\* This information will be handled in strict accordance with the Family Educational Rights and Privacy Act of 1996 (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPPA).