Vanderbilt Sports Medicine

AUTHORIZATION TO USE OR DISCLOSE MEDICAL INFORMATION

PATIENT IDENTIFICATION	
Name:_____	Date of Birth:_____
SSN:_____	MRN: _____

I hereby authorize the physicians, athletic trainers, sports medicine staff, and other health care personnel of Vanderbilt University Medical Center ("VUMC") to use and share medical information related to my ability to train for and participate in athletic activities. This information may include specific health information related to relevant medical conditions or illnesses that may impact my training or participation, injuries and prognosis, and medical care and treatment provided to me. This information may be shared with or released to my parents/guardians, athletic coaches, strength and conditioning coaches, academic counselors, athletic or university administrators, chaplains or clergy members, the Southeastern Conference, and the NCAA Injury Surveillance System.

I also authorize members of the Vanderbilt University Athletic Department, VUMC personnel and communications staff to release health information related to my ability to train and participate in athletic activities to representatives of the media. This information related to relevant medical conditions or illnesses that may impact my training or participation, injuries and prognosis, and medical care treatment provided to me.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain medical treatment, however it may affect my ability to participate in University athletic activities under University Athletic Department policy. I understand that I may revoke this authorization at any time by notifying the Director of Sports Medicine, but such revocation will not have any effect on actions Vanderbilt University or VUMC may have already taken in reliance on this authorization. This authorization will expire one year from the date it is signed.

I understand that the information released may be subject to re-disclosure by some recipients and may no longer be protected by federal privacy rules related to individually identifiable health information.

Signature of Athlete/:_____ **Date:**_____
Legal Representative

Relationship to Athlete (e.g. Parent):_____

(A copy of this signed form should be provided to the patient)