**ATHLETIC RELEASE OF INFORMATION - AUTHORIZATION OF DISCLOSURE**

**Ashland University Student Health Center**

**401 College Avenue · Ashland, Ohio 44805**

**Phone: 419.289.5200 · Fax: 419.289.5209**

All matters relating to student athlete’s records are considered confidential and are treated as such by the Student Health Center Staff. Information regarding such matters cannot be given without the consent of the student athlete.

**Student Athlete’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ashland University Student Health Center and Ashland University Athletic Training Staff** are hereby granted permission to exchange medical information relating to an injury/illness that affects or may potentially affect my collegiate athletic participation.

**Purpose or need for disclosure:** This exchange of information will assist in the appropriate planning and treatment for the student athlete.

**The medical information listed above may also be released to the following:**

□Coaching Staff for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (my sport)

□Parent(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Other – Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I voluntarily consent to the disclosure of the above requested information. No threat or coercive measures have induced me to sign this consent form. I hereby further release Ashland University Student Health Center and Ashland University Athletic Trainers from all legal responsibility or liability that may arise from the act that I have authorized above**. This release of information will remain in effect for this academic year only.**

**Student Athlete’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sign here only if revoking permission to release information.**

I have the right to STOP this release of information at any time. Although I understand that I cannot do anything about information I previously said could be shared, I now want no more information shared and I am withholding consent.

***Signature of Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Notice: Prohibition on re-disclosure to anyone receiving information***

*This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part I) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization form the release of medical or other information is not sufficient for this purpose.*