HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.
Parts 160 and 164)**

1. Authorization
I authorize _____ (Athletic Trainer) to use
and disclose the protected health information described below to:

Scholastic Rowing Association of America® (SRAA®).

2. Effective Period
This authorization for release of information covers the period of healthcare
from:
___**August 1, 2018_____ to _May 31, 2019**_____.

3. Extent of Authorization

1. I authorize the release of my health assessment and information pertinent to the SRAA® Lightweight Health Certificate.
2. This authorization shall be in force and effect until __May 31, 2019____ at which time this authorization expires.
3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
4. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

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Date