

Sisters of Charity Providence Hospitals
Authorization To Disclose Protected Health Information

Student's Full Name

Date of Birth

Social Security Number

Name of School

Name of Program

I authorize Providence Hospitals to use or disclose Protected Health Information to the following:

The School and any individual involved in the operation of the Program, including without limitation coaches, referees, and athletic directors.

I authorize Providence Hospitals to use or disclose Protected Health Information for the following purpose(s):
To inform the above named individuals of sports injuries sustained by the Student.

Type of information requested:

Verbal or written protected health information related to sports injuries.

I UNDERSTAND THAT:

- The Protected Health Information used or disclosed under this authorization may be subject to redisclosure by the receiver and no longer protected by the Standards for Privacy of Individually Identifiable Health Information.
- I understand that treatment, payment, enrollment in a health plan or eligibility for benefits may not be conditioned on whether I sign this authorization.
- If I have any questions about the disclosure of my Protected Health Information, I can contact the Release of Information staff of Health Information Management Services at Sisters of Charity Providence Hospitals (803 256-5722).
- I understand that I may revoke this authorization in writing except to the extent that Providence Hospitals has previously used or disclosed the Protected Health Information in reliance on this authorization. To revoke this authorization, I understand that I must deliver a signed written statement clearly stating that I revoke this authorization to Health Information Management Services, Sisters of Charity Providence Hospitals, 2435 Forest Drive, Columbia, SC 29204.

This authorization expires six months from the date of signature, or on: _____.

Authority or Relationship of Representative
(Unless parent, attach copy of documentation of authority,
e.g., a court order designating guardianship)

Signature of Personal Representative/Guardian

Signature of Student

Date