Daytona State College
Sports Medicine Department

INDIVIDUAL CONSENT FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and practice operations as described in our Notice of Privacy Practices. You have the right to revoke this consent, in writing, except where we have already made disclosures or used your information based upon your prior consent.

Consent Related to HIV/AIDS Information
The information we use or disclose as described in our Notice of Privacy Practices may include information about Acquired Immunodeficiency Syndrome (AIDS), or tests for or infection with the Human Immunodeficiency Virus (HIV). You consent to the use or disclosure of this health information for treatment, payment, or practice operations as described in our Notice.

Consent Relating to Mental Health or Substance Abuse
The information we use or disclose as described in our Notice of Privacy Practices may contain information regarding psychiatric conditions, alcohol or substance abuse. You consent to the use or disclosure of this health information for treatment, payment, or practice operations as described in our Notice.

I consent to the use and disclosure of all of my health and medical information between the Daytona State College Sports Medicine team (physicians, athletic trainers, coaches), parents, hospitals, physical therapists, other healthcare providers and insurance companies related to my past and present medical conditions, injuries, or illnesses, as described in the Notice of Privacy Practices and in the paragraphs above. By signing below, I also acknowledge receipt of said Notice.

Athlete Printed Name: _____ **Sport:** _____

Athlete Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____
(if under 18)
Parent/Guardian Printed Name: _____

Witness Signature: _____ **Date:** _____
