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LIBERTY UNIVERSITY OFFICE OF ATHLETICS COMPLIANCE

Student-Athlete Authorization/Consent for Disclosure of Protected Health Information

I,_____ hereby authorize _____
Student Athlete Name — Name of my Institution

and its physicians, athletic trainers and health care personnel to disclose my protected health information including, without limitation, any information regarding any injury, illness, treatment or participation related to or affecting my training for and participation in intercollegiate athletics to the National Collegiate Athletic Association (NCAA), and its designated employees, agents and/or contractors. I further authorize the NCAA to disclose, and/or use, such information as provided herein.

I understand that my participation and protected health information, including, without limitation, injuries or illnesses resulting from or affecting training for or participation in athletics, may be disclosed to, and/or used by, the NCAA, and any third party expressly authorized by the NCAA to receive such information for the purposes described in this paragraph. The information provides NCAA committees, athletics conferences and individual schools and NCAA-approved researchers with injury, relevant illness and participation information that does not identify individual student-athletes or schools. The data provide the Association and other groups with an information resource upon which to base and evaluate the effectiveness of health and safety rules and policy, and to study other sports medicine questions. Selected de-identified summary (aggregate) data also are made accessible to the general public as a service to further the general understanding of athletic injury patterns.

I understand that my protected health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition or withhold any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA athletics.

I understand that while HIPAA regulations may not apply to NCAA use or disclosure of my injury/illness information, the NCAA is committed to protecting my privacy. I understand that my protected health information and any personal identifiers will be encrypted while being transmitted from my institution and, to the extent kept by the NCAA, that all such data will be stored securely within industry standards. I further understand that neither the NCAA nor its agents or contractors will identify me personally in any publication or disclosure of research results. This authorization/consent for transfer of protected health information expires 545 days from the date of my signature below but I have the right to revoke it in writing at any time by sending written notification to the director of athletics at my institution. I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

_____ _____
Student Athlete Signature — Date