Wichita State University-ICAA Consent Form

Consent to treatment:

By signing the Policy Acknowledgement form, I hereby grant consent for treatment or services to be provided by WSU-ICAA athletic training staff. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Disclosure of Protected Health Information:

I understand that my injury/illness 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 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 or conference athletics.

I understand that my protected health information will or could be used by the Missouri Valley Conference, local, regional and national media, the Via Christi Regional Medical Center and related medical professionals, the WSU-ICAA athletic training staff and/or WSU-ICAA officials for purposes of providing athletic training and medical services, reporting and providing information about WSU Intercollegiate Athletics, and communications with the Conference.

I herby consent to and authorize Wichita State University and/or the WSU Intercollegiate Athletic Association, Inc. and its physicians, athletic trainers and health care personnel to disclose protected health information and any related information regarding any injury or illness during my training for, and participation in, intercollegiate athletics to the individuals or entities noted above for the purposes stated. I also consent to and authorize the release of protected health information to my parents or guardians.

I also understand that the Missouri Valley Conference and local, regional and national media are not covered by the Buckley Amendment or HIPAA and that these legal requirements will not apply to the Missouri Valley Conference and local, regional and national media’s use or disclosure of my injury/illness information.

Insurance assignment of benefits:

I hereby assign to the designated physician and/or hospital payment of medical benefits otherwise payable to me. This authorization is valid for any and all insurance claims filed in behalf of the designated physician and/or hospital. This authorization is valid until written notice of cancellation is received by the designated physician and/or hospital.

Expiration or revocation:

This authorization/consent expires 380 days from the date of my signature on the Policy Acknowledgement Form, but I have the right to revoke it in writing at any time by sending written notification to the Athletic Director at Wichita State University. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent. I further agree that a photocopy of this authorization/consent has the same force and effect as an original.

DO NOT SIGN THIS FORM. REFER TO THE POLICY ACKNOWLEDGEMENT FORM.

7/20/2011