

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE

I consent to the use or disclosure of my protected health information by **Northwestern Oklahoma State of Intercollegiate Athletics, Division of Sports Medicine** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Northwestern Oklahoma State, Department of Intercollegiate Athletic Trainers, Team Physicians, and Sports Medicine Staff** may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare of the practice. **Northwestern Oklahoma State, Department of Intercollegiate Athletics, Division of Sports Medicine** is not required to agree to the restrictions that I may request. However, if **Northwestern Oklahoma State, Department of Intercollegiate Athletics, Division of Sports Medicine** agrees to a restriction that I request, the restriction is binding on **Northwestern Oklahoma State, Department of Intercollegiate Athletics, Division of Sports Medicine** and **Northwestern Oklahoma State Athletic Trainers, Team Physicians, and Sports Medicine Staff**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Northwestern Oklahoma State Athletic Trainers, Team Physicians, and Sports Medicine Staff** or **Northwestern Oklahoma State, Department of Intercollegiate Athletics, Division of Sports Medicine** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physicians, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Northwestern Oklahoma State, Department of Intercollegiate Athletics, Division of Sports Medicine's** Notice of Privacy Practices prior to signing this document. **Northwestern Oklahoma State, Department of Intercollegiate Athletics, Division of Sports Medicine** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Northwestern Oklahoma State, Department of Intercollegiate Athletics, Division of Sports Medicine** is also provided in the office of the Head Athletic Trainer, Northwestern Oklahoma State. This Notice of Privacy Practices also describes my rights at **Northwestern Oklahoma State, Department of Intercollegiate Athletics, Division of Sports Medicine** duties with respect to my protected health information.

Northwestern Oklahoma State, Department of Intercollegiate Athletics, Division of Sports Medicine reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by containing **Northwestern Oklahoma State, Department of Intercollegiate Athletics, Division of Sports Medicine** and requesting a revised copy be sent in the mail or asking for one in person.

Signature of Student-Athlete or Personal Representative _____

Name of Student-Athlete or Personal Representative _____

Date _____ Description of Personal Representative's Authority: _____