ST. OLAF COLLEGE SPORTS MEDICINE
Medical Care is contracted with Physicians from Allina Health

HIPAA CONSENT FORM

Dan Hagen ATC 507-786-3261 dhagen@stolaf.edu | Angie Enedy ATC 507-786-3720 enedy@stolaf.edu

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St. Olaf College

In accordance with HIPAA guidelines, I ______________________ give the following approvals for injuries resulting from participation in intercollegiate athletics programs at St. Olaf College. In the case of an injury from participation in intercollegiate athletics at St. Olaf College, the Athletic Training/Sports Medicine Staff may perform the following functions listed below.

By my signature I agree that the St. Olaf College Athletic Training/Sports Medicine Staff can function in that matter with my approval of release of injury or illness information.

It is approved that the Sports Medicine Staff give updates and injury/illness information related to the above sport to the Head Coach of that sport.

Initials________

It is approved that the Sports Medicine Staff may contact the St. Olaf College Health Service for information regarding injury/illness related to my participation as well as to consult with their staff in regards to conditions that may arise from participation.

Initials________

It is approved that the Sports Medicine Staff may contact via email, mail, or fax the Team Physician, Referral Physicians, Health Services, and insurance companies for consultation and to receive further information on any injury/illness that are related to intercollegiate athletics.

Initials________

_______________________________________________  _________________________________________________
Signature                  Date

Revised 2/2016
1. **Provider Record Locator:** A health record locator service helps my health care providers determine where I have received care and obtain information about my health to help treat me. Allina Health (“Allina”) may access my information in a record locator service to help provide care to me. Allina may share my health record and information with a health record locator service unless I check in the box below. If I check the box below, I understand Allina will exclude my information from any record locator services.

2. **Release of Information By Allina for Payment and Healthcare Operations:** I consent to the release of my health records and other information related to my health care services for payment and healthcare operations purposes. I agree that my health records and other information may be released to Medicare, my insurance company or health maintenance organization, other payers, other providers involved in my care, payer networks organizations, including accountable care organizations, in which my providers participate, and the contractors and third party administrators of any of these parties.

3. **Release of Information by Others for Payment and Healthcare Operations:** I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations including accountable care organizations, and their contractors and third party administrators to share my health records and information obtained from Allina, or any other provider, with Allina, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which my provider participates, and the contractors and third party administrators of these parties as needed for payment and health care operations.

4. **Release of Information to Health Care Providers:** I consent to the release of my health records created, received and maintained by Allina for my treatment to other health care providers who are involved in my treatment. This consent does NOT include release of information obtained by or created in a drug or alcohol abuse treatment unit.

5. **Consent for Use of Medical Records in Research:** I authorize Allina Health to use or disclose my medical records for research, including health records created by Allina and those records Allina receives form other health care providers while treating me unless I check here.

This consent will continue forever unless you cancel it by writing us at: Allina Health Information Management, Mail Route 20300, 2828 10th Ave, S, Minneapolis, MN 55407; but if the consent is cancelled; it will not change releases that have already been made.

_________________________________________________  ___________________________________________________
Patient or Legal Representative Signature  Date/Time

_________________________________________________  ___________________________________________________
Legal Representative Printed Name (if signing for patient)  Authority to sigh for patient (attach documentation)