Athletic Health Care

Notice of Privacy Practice
Protected Health Information (HIPPA)[08]

Name: _____ Date: _____

Sport: _____

I authorize the Athletic Trainer of MCCC to make appropriate use of my protected health information **(social security number, date of birth, health insurance provider, and medical condition)**.

This information would be provided to medical facilities as necessary to schedule appointments and/or obtain results of tests performed and information concerning current health status.

I realize that I cannot be denied treatment if I decide not to sign this form or choose to revoke this authorization prior to the expiration date.

Signature: _____ Date: _____

*******Expires with every school year*******

Athletic Training Room
Phone: (609) 570-3747
Fax: (609) 570-3875