



**HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PERSONAL AND MEDICAL INFORMATION TO OHIO NORTHERN UNIVERSITY**

To: \_\_\_\_\_  
Name of Provider

\_\_\_\_\_  
Address of Provider

From: Below Signed ONU Intercollegiate Athlete

**YOU ARE HEREBY AUTHORIZED TO RELEASE TO:**

Ohio Northern University  
Athletic Training Department  
Sports Center  
525 South Main Street  
Ada, OH 45810-1599

**the following health information:**

\_\_\_\_\_  
**for the purpose of my continued participation in ONU's intercollegiate athletic programs.**

This Authorization is a free and voluntary act by me. I understand that, if the Provider is rendering services to me solely for the purpose of disclosing the health information generated thereby to the person designated in this Authorization, my failure to provide this Authorization may result in a denial of service by the Provider. Otherwise, I understand that my Provider cannot condition my treatment on my signature on this Authorization.

This Authorization will be valid until \_\_\_\_\_ or until I am no longer a fulltime student at Ohio Northern University. I know that I may revoke this Authorization at any time, except to the extent that the Provider may have taken action in reliance thereon, by notifying Provider in writing at the address given above. I also understand that the Provider cannot limit or control the subsequent use, reproduction, or dissemination of the health information I have authorized to be released. A copy of this Authorization is as valid as the original.

**INDIVIDUAL'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_

**IF UNDER 18 YEARS OF AGE, COMPLETE THE FOLLOWING.**

**PERSONAL REPRESENTATIVE SIGNATURE:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_

**DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT FOR THE INDIVIDUAL:**

\_\_\_\_\_