

UNIVERSITY OF ILLINOIS
AT SPRINGFIELD

Campus Health Service
Division of Student Affairs
Business Services Building, Room 20
One University Plaza, MS BSB 20
Springfield, Illinois 62703-5407

ATHLETIC HEALTH CONSENT FORM

_____ was seen in the Campus Health Service on _____
(student's name) *(date)*

It is our opinion that he/she should not practice or play until _____. Your understanding and cooperation in this matter will be appreciated.

- The student declines to authorize the release of his/her medical information due to confidentiality.
- The student has authorized the release of his/her medical information. The student has been treated/referred for:
Athletic / Trainer

Consent is valid until _____ *(no more than 90 days)*.

I understand that I may revoke this authorization at any time and that the above-mentioned person authorized to receive this information has the right to inspect the information to be disclosed.

It has been explained to me that if I refuse to consent to this release of information, the following are consequences:

unable to play

(Specify, if any)

I hereby authorize the University of Illinois at Springfield Campus Health Service to release any or all information acquired during the course of my examination and/or treatment to the Athletic Trainers/Coaches.

Signature of athlete

Date signed

Witness

UIN

5.07-00356-44308