

**Oklahoma Panhandle State University  
Athletic Training**

**NOTICE OF PRIVACY PRACTICES**

1. We have a legal, ethical, and moral obligation to protect your confidentiality. Any information about you will be held in strict confidentiality by all staff members. No discussion about you, outside the patient care framework, will be permitted, and any conversation among staff members that pertains to delivering you quality care will be held in a confidential and professional manner.
2. In order to provide quality care to you, as well as operate this department in an efficient manner, we will need to access your private health care information for purposes of treatment, payment, and operations (such as quality assurance). In using this information, this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy and Security protections afforded you by the Health Insurance Portability and Accountability Act (HIPPA).
3. Specifically, we will disclose your private information under the following circumstances:
  - a. **Sharing information for purposes of treatment:** We will share information with all members of your treatment team, both within this department and with other providers (personal and institutional) in order to provide you with quality integrated care.
  - b. **Sharing of information with athletic department personnel:** We will share information with your coaching staff, OPSU sports information (media), and parents, guardians, or other people you give us permission to inform.
  - c. **Sharing of information for purposes of payment:** We will share all necessary information with your insurer(s), payer(s), government entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review).
4. Your consent for use and disclosure of information as described may be revoked in writing at any time. Please notify the Head Athletic Trainer if you ever decide to revoke your consent.
5. Your specific authorization will be required for the release of any information not included above. Your authorization will need to be in writing and it will be specific to the disclosure requested. Incidences which may require your authorization under the HIPPA regulations include but are not limited to:
  - \*Marketing purposes
  - \*The disclosure of any psychotherapy records in our possession
  - \*Disclosure for fundraising by an entity
6. This department will not release any information on any athlete (other than stated above) without signed release from the patient unless required by law.
7. You have the right to inspect and copy your protected information, amend your record, have reasonable requests for confidential communications accommodated and may obtain an accounting of disclosures. All other rights afforded to you by the state and federal law will be honored. Please contact the Head Athletic Trainer if you have any questions about your rights or any other privacy related questions you may have.
  - \*If you wish to amend your record, it is to be done in the office on a separate sheet of paper. In **NO CASE** is the original record itself to be altered or defaced by the patient. The original record may not leave the office premises unless required to do so by law.
8. This department has policies and procedures in place to facilitate compliance with the law, as well as to assure that this office consistently treats you with respect for your privacy and with confidentiality concerning your medical information. These policies and procedures are available for you to review. If you would like to read them please contact the Head Athletic Trainer.
9. The Head Athletic Trainer is the person in the department responsible for your privacy and the security of your information. Any complaints you may have in this area should be directed to the Head Athletic Trainer or the Athletic Director.

**ATHLETE CONSENT FOR THE DISCLOSURE INFORMATION**

**I have read the NOTICE OF PRIVACY PRACTICES and have had any questions answered by this department. I understand that by signing this form I consent to the following areas that are initialized**

- \_\_\_\_\_ A. **Sharing information for purposes of treatment:** You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care.
- \_\_\_\_\_ B. **Sharing of information with athletic department personnel:** You will share my medical information with my:  
\_\_\_\_\_ Coaching Staff  
\_\_\_\_\_ OPSU sports Information  
\_\_\_\_\_ Others (Parents/Guardians/Spouse) as listed here: \_\_\_\_\_
- \_\_\_\_\_ C. **Sharing of information for purposes of payment:** You will share all necessary information with my insurer(s), payer(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives.

**IN ADDITION:**

1. I authorize Oklahoma Panhandle State University Athletic Training Department to use answering machines or voice mail systems, a cellular or cordless telephone, and/or a fax machine, to discuss or transmit information about my condition as necessary despite the fact that these conversations may be intercepted or overheard by other persons, although this is not routinely anticipated.
2. Failure to sign this consent will prevent me (my son/daughter) from participating in intercollegiate athletics at Oklahoma Panhandle State University. My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosure given in reliance on this prior consent will be permissible.

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Print Name

Signature

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Date

Parent/Guardian Signature (if under 18 years of age)

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Signature to Decline

