I, ____________________________ hereby authorize _____________________________________

Name of Student-Athlete  Name of my Institution

and its physicians, athletic trainers and health care personnel to disclose my protected health
information and any related information regarding any injury or illness or participation related to my
training for and participation in intercollegiate athletics to the National Collegiate Athletic
Association (NCAA) and its employees or agents.

I understand that my participation and protected health information will be used by the
NCAA’s Injury Surveillance System (ISS), a longitudinal surveillance database maintained by the
NCAA, for the purpose of monitoring injuries resulting from training for or participation in athletics.
The ISS provides NCAA committees, athletic conferences and individual schools and NCAA-
approved researchers with injury and participation information that does not identify individual
athletes or schools. The data provide the Association and other groups with an information resource
upon which to base and evaluate the effectiveness of health and safety rules and policy, and to study
other sports medicine questions. Selected de-identified summary (aggregate) data also are made
accessible to the general public as a service to further the general understanding of athletic injury
patterns.

I understand that my injury/illness information is protected by federal regulations under
either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational
Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either
my authorization under HIPAA or my consent under the Buckley Amendment. I understand that my
signing of this authorization/consent is voluntary and that my institution will not condition or
withhold any health care treatment or payment, enrollment in a health plan or receipt of any benefits
(if applicable) on whether I provide the consent or authorization requested for this disclosure. I also
understand that I am not required to sign this authorization/consent in order to be eligible for
participation in NCAA athletics.

I understand that while HIPAA regulations may not apply to the NCAA’s use or disclosure of
my injury/illness information, the NCAA is committed to protecting my privacy. I understand that
the protected health information and any personal identifiers will be encrypted while being
transmitted from my institution to the NCAA and that all data will be stored on a secure server at the
NCAA national office in Indianapolis, Indiana. I further understand that neither the NCAA nor the
ISS will identify me personally in any publication or disclosure of research results.

This authorization/consent for transfer of protected health information expires 545 days from
the date of my signature below, but I have the right to revoke it in writing at any time by sending
written notification to the athletics director at my institution. I understand that a revocation takes
effect on its request date and does not affect any action taken prior to that date.

Printed Name of Student-Athlete  Signature  Date