



AUTHORIZATION FOR DISCLOSURE AND RECEIPT OF MEDICAL INFORMATION FOR ENROLLED STUDENTS WITHIN THE LOS ANGELES COMMUNITY COLLEGE DISTRICT
West Los Angeles College

Student Name: _____ SID#: _____

(THIS SECTION TO BE COMPLETED BY ALL STUDENTS)

_____ (initial here)
 I hereby authorize the following entities to **disclose** or **receive** my **medical information** and **claims administration information** for the purpose of claims administration: the DISTRICT's Risk Management department, and/or the WEST LOS ANGELES COLLEGE (the "COLLEGE") athletic training staff. As used herein and below, "**medical information**" includes my medical history, record of injury or surgery, record of serious illness, and/or rehabilitation results. "**Claims administration information**" includes, but is not limited to, billing, payments, claim status and related information pertaining to injuries or illness sustained while I am a student.

(THIS SECTION TO BE COMPLETED BY STUDENT ATHLETES ONLY)

_____ (initial here)
 I hereby authorize the following entities or individuals to **disclose** or **receive** my **medical information** for the purpose of allowing such entities or individuals to assist and/or participate in providing health care services to me while I am a student athlete: Student Health Center providers, and/or the appropriate coaching staff, athletic training and medical staff, and athletic administration at the COLLEGE.

_____ (initial here)
 I hereby authorize the COLLEGE athletic training and medical staff to **disclose** my **medical information** to outside physicians or health care professionals for the purpose of advising such individuals of my medical conditions and injuries or illnesses sustained while I am a student athlete.

_____ (initial here)
 I hereby authorize the COLLEGE athletic training and medical staff to **disclose** my **medical information** to scouts or representatives of professional or amateur athletic organizations for the purpose of assisting such organizations.

_____ (initial here)
 I hereby authorize the COLLEGE athletic training and medical staff to **disclose injury briefings** to the COLLEGE sports information director and local media for the purpose of reporting an injury and its effect on my participation status. As used herein, an "**injury briefing**" will include, but is not limited to the following: my name, injured area, disposition and current status.

I understand that only the minimum necessary information will be released to accomplish its intended purpose. All other information that is not relevant to my status as a student or student athlete will remain confidential.

This authorization shall remain in force and active for the duration of my enrollment at the COLLEGE. I may revoke this authorization at any time, by filing a written notice with the COLLEGE administration and/or athletic training department. I understand that if I am a student athlete and I choose to revoke this authorization, I may be unable to continue my intercollegiate athletic participation at the COLLEGE.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by third party recipients. A copy of this authorization shall be considered as valid and effective as the original.

Date: _____

 Print Name of Student

 Signature of Student

Date: _____

 Signature of Parent/Guardian, if student is a minor