

Bowie State University
Consent for Purposes of Treatment, Payment and Health Care Operations
Bowie State University Sports Medicine Department

I consent to the use or disclosure of my protected health and insurance information by the Bowie State University Sports Medicine Department for the purpose of diagnosing or providing treatment to me, obtaining payment information for my health care bills, or releasing any information for clearing house/professional team purposes. My “protected health information” means medical, billing and demographic information about me collected from me and created or received by the Bowie State University Sports Medicine Department for treatment, payment and health care operations.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Bowie State University is not required to agree to the restrictions that I may request. However if Bowie State University agrees to a restriction that I request, the restriction is binding. All restrictions must be made known to the Bowie State University Sports Medicine Department in writing with both the head athletic trainer’s and my signature.

Name of Student Athlete _____

Signature of Student Athlete _____

Date _____