HUNTINGDON AREA SCHOOL DISTRICT

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I, _____(parent/guardian), as the parent/guardian of _____, a student-athlete, understand that participation in athletic activities may result in injury. I also understand that when injuries arise, immediate action must be taken. In order to secure immediate care/treatment for _____, certain protected health information/personally identifiable information may need to be released by School District representatives to medical personnel.

By signing this form, I hereby authorize the School District's physicians, athletic trainers and other healthcare personnel to disclose _____'s protected health information to other healthcare providers, hospitals, medical clinics, laboratories, medical insurance coordinators, athletic coaches and the School District's Administration. Disclosures may include information pertaining to a specific injury, illness, or medical condition, or the student's medical status, prognosis, diagnosis, and other protected health information.

This authorization is only valid for the _____ school year. I understand that I have the right to revoke this authorization prior to the conclusion of the school year by submitting written notification to the Athletic Director.

_____ Date:_____

Name of Student

_____ Date:_____

Signature of Parent