

MAHANOY AREA SCHOOL DISTRICT

RELEASE OF STUDENT CONFIDENTIAL HEALTH INFORMATION

Name of Student: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Name of Person to Contact if Parents are unavailable: \_\_\_\_\_

Phone Number of Emergency Contact: \_\_\_\_\_

Family physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Hospital Preferred: SchMed Center East \_\_\_\_\_ Sch Med Center South \_\_\_\_\_ Other \_\_\_\_\_

I, \_\_\_\_\_, (Parent/Guardian) authorize the release of the following health and/or behavioral information to the Athletic Department of the Mahanoy Area School District:

Health Information (include medications, allergies): \_\_\_\_\_

\_\_\_\_\_

Basically, athletic coaches, trainer and other athletic personnel need to know about these confidentiality issues because it is important that they have information about student athletes. It may be critical that coaches have:

1. Student emergency information
2. Information about student's medical needs that may impact their sport's performance.
3. Information about a student's disciplinary history, so that coaches and school administration can make appropriate decisions.

This consent will begin on the date of this authorization and will expire one year later unless revoked by me in written form.

I understand the confidentiality of the above information is protected by State and Accountability Act of 1996(HIPPA). The information cannot be released without my written authorization except under special circumstances as provide by the same laws and regulations.

Prohibition on Disclosure: Confidential information has been disclosed by you. This confidentiality is protected by State and Federal Laws. State and Federal laws including HIPPA prohibit the School District from making any further disclosures of this information unless further disclosure is expressly permitted by the written Authorization of the person to whom it pertains. A general authorization for the releases of medical or other information in NOT sufficient for this purpose.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date of Authorization

