

MANDATORY HIPAA FORM FOR ATHLETES!!

All student athletes are required to complete and return the following **RELEASE** form. This form will be required to ensure that we are in compliance with the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA law was put in place to ensure confidentiality of individuals requiring medical care. Every athlete has their individual rights protected for medical records. Even though our Certified Athletic Trainers have "shared" medical information on the athletes for years between Physicians and coaches, we must now by federal law have a signed authorization form permitting Geisinger to disclose protected health information about the student/athlete to the coaching staff. This would include the injury specifics, severity of the injury, and the status to return to play. In order for your son/daughter to be able to participate in athletics, a copy of this form will need to be on file at the school. This form will only need to be completed one time per year prior to the start of the sport season. These forms will be available in the main office at your school. We appreciate your help in ensuring that this form is completed and turned in prior to your son/daughters sports season.

Sincerely,

Roxanna Larsen, MS, LAT, ATC
Director of Sports Medicine, Orthotics, and Fitness
Musculoskeletal Institute
Geisinger
115 Woodbine Lane
Danville, PA 17822-5212
Office 570-271-6700 option 3
rllarsen@geisinger.edu

AUTHORIZATION TO RELEASE ATHLETIC MEDICAL INFORMATION

Patient Name: _____
 Address: _____
 Address: _____
 Birthdate: _____
 Medical Record No.: _____

• GEISINGER EMPLOYEE USE ONLY •

<input checked="" type="checkbox"/> Geisinger Medical Center 100 N. Academy Avenue Danville, PA 17822	<input checked="" type="checkbox"/> Geisinger Wyoming Valley Medical Center 1000 E. Mountain Boulevard Wilkes-Barre, PA 18711	<input checked="" type="checkbox"/> Geisinger Clinic (GMG) _____ _____ (Specify site and address)
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(AS APPLICABLE)

I authorize an appropriate workforce member of the above entity(ies) to release information from my medical record to: Officials of the school that I (Student Athlete) attend. This would include, the coaching staff, athletic directors, insurance carriers and health-care professionals who are involved with my participation in interscholastic athletics.

(Address and Phone number of receiving party)

for the purpose of: continuation of medical treatment payment of bill Worker's Compensation
 education legal purposes insurance purposes at the request of the patient or the patient's legal representative for personal access or other (specify): _____

The information to be released will cover the time period from 6/2019 to 6/2020

SPECIFIC INFORMATION TO RELEASE:

- All information concerning my health that impacts my ability to participate in interscholastic athletics. This may include information about injuries (such as sprains), surgeries, or medical conditions (such as concussions, asthma etc.). This is to inform the above referenced people of my health –related limitations and abilities to continue to participate in interscholastic athletics.
- To provide the above referenced people with information on how to help me safely participate in Interscholastic athletics

I understand that in order to process this request for the reproduction of medical record information on a timely basis, the above entity(ies) may utilize a contracted medical record copy service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that this authorization is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I will contact the above entity(ies) immediately if I wish to revoke this authorization. As described in the Notice of Privacy Practices for the above entity(ies), I may request such Notice of Privacy Practices for my ease of reference. I understand that the information released may be re-released by the recipient and may no longer be protected by HIPAA (Federal regulations). The above entity(ies) may not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is requested (i) to provide research-related treatment to me, or (ii) because the health care being provided to me is solely for the purpose of creating protected health information for disclosure to a third party.

SPECIAL AUTHORIZATION (if applicable)

If you are authorizing the above entity(ies) to release information related to the testing, diagnosis and/or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information to be released.

_____ Parent/Guardian	_____ Patient/Athlete	My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted above.
_____ Parent/Guardian	_____ Patient/Athlete	My evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation and/or neuro-psychological information may be released to the recipient noted above.
_____ Parent/Guardian	_____ Patient/Athlete	My testing, diagnosis or treatment for HIV/AIDS may be released to the recipient noted above.

AUTHORIZATION SIGNATURES

Date: _____ Patient/Athlete Signature: _____
 Date: _____ Witness Signature: _____
 Date: _____ Parent/Guardian Signature: _____
 Date: _____ Witness Signature: _____

*****COPY OF COMPLETED AUTHORIZATION FORM MUST BE GIVEN TO PATIENT*****

Copy: Medical Record

Copy: Patient