STUDENT HIPAA AUTHORIZATION

By my signature, I authorize use or disclosure of protected health information about the Student as described below.

1. The following specific person/class of persons/facility is authorized to use or disclose information about the Student: *St. Bernard's Hospital, Inc. dba St. Bernards Medical Center, Cardiology Associates of Jonesboro, Inc. dba St. Bernards Heart & Vascular, the Student's athletic trainer and any providers performing physical exams on the Student at St. Bernards Health & Fitness Expo(s)*

2. The following person (or class of persons) *may receive disclosure* of protected health information about the Student: *Any and all coaches, athletic trainers, athletic directors, health care providers, medical staff and teachers and others as necessary to evaluate or communicate the Student's health status and ability to participate in athletic events. This authorization also authorizes the persons listed in Sections 1 and 2 to upload and maintain the Student's information to SportsWare OnLine. The authorization also allows persons listed in Section 1 to disclose the Student's protected health information to his or her parent (or adult standing in loco parentis or guardian prior to Student obtaining majority) as necessary to coordinate the student's care or participation in athletic events.*

3. The specific information that should be disclosed is (psychotherapy notes are excluded): *Any and all protected health information necessary to evaluate or communicate the Student's health status and ability to participate in athletic events*, *including all information that is generated as a result of Student's participation in physical exams at St. Bernards Health & Fitness Expo and information maintained on SportsWare OnLine. The information released may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency syndrom (HIV). It may also include information about mental or behavioral health services or treatment for alcohol or drug abuse.*

4. The information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. The authorization may be revoked by notifying Daya Shipman, 225 E. Washington, Jonesboro, AR 72401 (870-207-4422), in writing of your desire to revoke it. However, any action already taken in reliance on this authorization cannot be reversed, and revocation will not affect those actions. The medical provider to whom this authorization is furnished may not condition its treatment of the Student on whether or not the authorization is executed.

6. The purpose for/intended use of the information is: *to allow the Student's athletic trainer, athletic director coaches, providers and others to evaluate and communicate the Student's health status and ability to participate in athletic events.*

7. This authorization expires: *upon the Student's graduation or withdraw from high school.*

A copy of this completed, signed and dated form must be given to the individual or other signator.

Student Name:_____ Date of Birth: _____

Signature of Student (if student is over 18): _____

Signature of Personal Representative (if Student is not over 18):_____

Relationship (ex. Parent or Legal Guardian): _____

Date: _____

IF STUDENT IS A MINOR, A PARENT OR LEGAL GUARDIAN MUST EXECUTE THE AUTHORIZATION.