PANHANDLE AREA EDUCATIONAL CONSORTIUM

FIELD TRIP

MEDICAL INFORMATION RELEASE AUTHORIZATION

The Federal Health Insurance Portability and Accountability Act , commonly referred to as HIPAA, requires an individual, or the individual's legal representative (parent of a minor, legal guardian, trustee, power of attorney) to provide permission for the release and exchange of that individual's health information in certain circumstances. If you sign this form, you are giving the health care providers designated below permission to share the information you indicate below. This form complies with the provisions of 45 C.F.R. § 164.508(c) regarding authorizations for release and exchange of protected health information. This form must be filled out entirely.

Purpose of Authorization: This form is designed to allow designated coaches, sponsors, athletic trainers, and school appointed chaperones to obtain health information necessary to determine a student's fitness and eligibility to participate in extracurricular/sports activities and/or field trips.

Please complete the following:

I/we the parents or legal guardian of _____, an extracurricular/sports participant of the school or person/student traveling on a field trip, give the authorization as indicated below for the communication between medical providers and activity sponsors relative to the status of participation. Student Date of Birth_____

FROM MEDICAL PROVIDERS INDICATED BELOW:
Circle One Only:

A. All Providers

B. No Providers

C. Limited Providers

1 All providers except: _____

2 No providers but: _____

TO DESIGNATED COACHES, SPONSORS, ATHLETIC TRAINERS OR OTHER SCHOOL APPOINTED CHAPERONES:
Circle One Only:

A. Entire Health Record.

B. No protected health information.

C. Limited protected health information (describe information you do not wish for the provider to disclose, including any relevant time periods).

Enter the date that you want this authorization to expire. (If you do not enter a date, this authorization will expire one year from the date this form is signed.) _____

I understand that the information described above may be redisclosed by the person or group that I give the abovespecified health care providers permission to share my information with, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release the providers identified above from all liability arising from the disclosure of my health information pursuant to this agreement.

I understand that I may inspect or request copies of any information disclosed by this authorization. I understand that I may revoke this authorization by notifying the Panhandle Area Education Consortium and the specified health care provider, in writing, knowing that previously disclosed information would not be subject to my revocation request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility for benefits.

I have been provided with a copy of this authorization.

Signature of Parent or Legal Guardian Date

Printed Name of Parent or Legal Guardian Relationship to Student.

If there is a legal document verifying that you are acting in a representative capacity for the student identified above, please attach a copy to this authorization.

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INTRODUCTION The privacy of medical records and information is protected and insured by new legislation entitled the Health Insurance Portability and Accountability Act ("HIPAA"). This law was developed to safeguard information about an individual's medical status from improperly being shared, discussed or released without their knowledge. The law is totally inclusive and does not allow for the beneficial communication about medical conditions or status absent valid authorization.

CONCERN – When an individual, especially a minor, participates in an extracurricular activity/field trip, there is always potential for injury or illness that may limit or prohibit participation. In order to make good decisions about the participation status of an individual, sponsors, coaches, directors, and chaperones need information concerning the individual participant's health status. Under the HIPAA regulations, that information may only be given by the parent or guardian of the minor participant (under 18) or the nonminor participant (18 or over). Medical providers including doctors, physical therapists, nurses, trainers, etc. may not directly discuss any medical condition of an extracurricular activity participant with the director of the activity without written consent from a parent or guardian or the adult participant.

REQUEST FOR CONSENT – Medical providers respect the right to privacy but also understand the need to communicate with activity directors about the participation status of individuals in their care. To accomplish this, a written consent form must be completed indicating the extent that this communication may occur. Three basic levels of consent are possible. These are A. TOTAL CONSENT, B. NO CONSENT, C. LIMITED CONSENT. This form is a request for a parent/guardian or adult participant to choose the level of consent desired. Included in the completion of this request form is the designation of what medical providers from whom medical information can be requested. There should be an understanding that total consent is still communication only BETWEEN those individuals who NEED to know the medical status of the participant. Since knowledge of certain medical information is necessary to determine the participation status and/ or the limitations of that participation (such as preseason medical screening), failure to release such information to the authorized sponsoring individual may disqualify the student from participating in extracurricular activities

STUDENT MEDICAL RELEASE FORM
PANHANDLE AREA EDUCATIONAL CONSORTIUM

Please fill this form out completely and sign

Student's Name _____ Circle one: Male Female

Date of Birth _____ Grade: _____ School Year: 20

Parent'(s) name(s)_____

Guardian(s) name(s)_____

Address:_____

City:_____ Zip: _____ Home Phone:_____

Work Phone: _____ Emergency Phone: _____ Cell Phone: _____

Email:_____@_____.___

…… I/We hereby give my/our permission for my/our child to attend the all school sponsored EXTRACURRICULAR/FIELD TRIPS and PARTICIPATE IN SPORTS events during the next 12 months, beginning in July 1, 20____ to June 30, 20____. I/We understand that there will be adult supervision at these events. I/We also understand that if there are any disciplinary problems with the above named Student, it will be our responsibility to pick up our child at the site of the event and they will not be eligible for future events without specific approval of the school staff in charge of those events or sports.

AUTHORIZATION FOR TREATMENT

I/We, the undersigned, parent(s)/Guardian(s) of the child named above on this consent form, do hereby authorize the school district, it's staff, our representatives, as agent(s) for the undersigned to consent to a X-ray examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care that is deemed advisable by, and is to be rendered under the general supervision of any physician, physician extender, and surgeon licensed under the provisions of the Medicine Practice Act on the Medical Staff of any Hospital or medical clinic whether such diagnosis or treatment is rendered at the office of said physician or said hospitable.

It is understood that this authorization is given in advance of any specific diagnosis, assessment at time of injury treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment deem advisable; and to include emergency or urgent care as deemed necessary by supervising personnel.

The authorization is given pursuant to the provisions of Section 456.057, Florida Statutes, which allows Parent(s) or Guardian(s) to authorize any adult to consent to medical or dental treatment as stated in the above paragraphs).

This authorization shall remain effective from the date below, unless sooner revoked in writing delivered to said agent(s).

Signed _____ Dated _____

Print Name _____

(Parent or Guardian)