BLOOMSBURG AREA ATHLETICS
HIPPA FORM
2024-25

AUTHORIZATION TO RELEASE ATHLETIC MEDICAL INFORMATION

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

• GEISINGER EMPLOYEE USE ONLY •

☒ Geisinger Medical Center
100 N. Academy Avenue
Danville, PA 17822

☒ Geisinger Wyoming Valley Medical Center
1000 E. Mountain Boulevard
Wilkes-Barre, PA 18711

☒ Geisinger Clinic (GMG) _____ _____ (Specify site and address)

(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.

Bloomsburg Area School District

(Address and Phone number of receiving party)

for the purpose of: x continuation of medical treatment x payment of bill ☐ Worker's Compensation x education x legal purposes x insurance purposes x 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 **JUNE 1, 2024 TO JULY 31, 2025**

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*