KENNEDY CATHOLIC FAMILY OF SCHOOLS ATHLETICS
HIPAA AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

& Sharon Regional Permission for Treatment

Sharon Regional Health System's Sports Medicine Services has been contracted to provide sports medicine services for the Kennedy Catholic High School and Middle School Athletes.

Should an athlete become injured at a KCHS sanctioned activity where arrangements have been made to have certified athletic trainer(s) on staff from Shron Regional Health System present, the certified athletic trainer(s) will provide basic emergency first aid care services and screen the athlete for further treatment or referred to a physician.

Should a medical emergency occur, we will make every effort to contact you about treatment for your daughter or son. In the event that you cannot be contacted, we ask that you give us permission to provide emergency medical treatment.

In the event that I cannot be contacted by telephone, I grant permission for the certified athletic trainer of Sharon Regional Health System to provide emergency treatment for:

_____ **(Daughter or Son)**
(Student Athlete's Name)

Parent/Guardian Name: _____
Address: _____
City **State** **Zip Code**

Phone Numbers and Time of day at each number I may be contacted:

Home: _____ **Time:** _____ **AM/PM**
Work: _____ **Time:** _____ **AM/PM**
Cell: _____ **Time:** _____ **AM/PM**

I hereby authorize Kennedy Catholic Family of Schools Athletic Department to release _____ 's Protected Health Information described below to: (Student's Name)

(Please check all that apply)

- All as listed below
- Athletic Trainer
- Team/School Doctor
- Intramural/Activity/Coaches
- Student's Principal/Vice Principal
- Student's Bus Driver
- KCHS/MS Athletic Staff (Director, Coaches, Assistant Coaches, Approved Volunteers, etc..)
- Student's Mother _____
- Student's Father _____
- Student's Legal Guardian _____
- The following persons: _____

Documents/Information to be released by the KCHS Family of Schools:

- ☐ ALL AS DEEMED APPROPRIATE
- ☐ ALL AS DEEMED APPROPRIATE, EXCEPT _____

Purpose of Disclosure (explain or indicate "at the request of the individual":

I understand theat the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPPA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to Kennedy Catholic Family of Schools Athletics Department's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in Kennedy Catholic Family of Schools' Notice of Privacy Practices. And understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to:

Kennedy Catholic Family of Schools
2120 Shenango Valley Freeway
Hermitage, PA 16148

I understand that I am no required to sign this authorization and that the Kennedy Catholic Family of Schools Athletic Department may not condition treatment on my execution of the authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient listed above and, in that case, will no longer be protected by HIPPA.

This authorization expires upon the Athletic Department's receipt of new annual form, graduation and/or withdrawal from the Kennedy Catholic Family of Schools.

I hereby acknowledge receipt of a copy of this authorization.

_____ _____ _____
Signature of Parent/Guardian or Emancipated Student **Relationship to Student** **Date**