AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)

Students Name _____ Date of Birth _____

1. I authorize the use or disclosure of the above named individual's health and injury information including the Initial and Interim Pre-Participation History and Physical Exam information pertaining to a student's ability to participate in North Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information.

2. The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers and other school personnel involved in the care of this student.

3. This information for which I am authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student relating to health conditions or injuries during the year that may effect participation.

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization.

5. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

6. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in extracurricular activities depends on such authorization. I need not sign this form to ensure healthcare treatment.

7. This authorization will expire one year from the date of signature.

_____ _____

Signature of Student Date

_____ _____

Signature of Parent Date