Student-Athlete Authorization and Consent Form for Disclosure of Protected Health Info

I hereby authorize the athletic trainer and other health care personnel representing Marshall High School to release information regarding the student-athlete's protected health information and related information regarding any injury or illness during the student-athlete's training for and participation in athletics at Marshall High School. I further understand that it is at my request to comply with the requirements of his/her school and the release of protected health information to a coach, athletic director, or school official in connection with participation in interscholastic sports. This protected health information may concern the student-athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected information may be released to other health care providers, hospital and/or medical clinics and laboratories, athletic coaches, medical insurance coordinators, athletic and/or school administrators, chaplains and/or clergy members, and officials of the WCAL and CIF.

I, _____, parent and/or guardian of _____, student-athlete, understand that as a parent/guardian give authorization/consent for the disclosure of the undersigned student-athlete's protected health information is a condition for participation as an interscholastic athlete at Marshall School. I understand that my protected health information may be protected by the federal regulations under the Health Information Portability and Accountability Act (HIPAA) and, if so, may not be disclosed without either parent/legal guardian authorization under HIPAA. This authorization/consent expires one year from the date it is signed.

Important: Your Rights. I understand my rights, as described herein:

- I may revoke this authorization at any time by notifying the Marshall High School's Athletic Director in writing. My letter must be hand delivered or mailed to the School.
- A revocation will not affect any uses or disclosures that Marshall School made before it received my revocation.
- If I request it, I may see a copy of the health information described on this form.
- The information that is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. I have the right to seek assurances from the above named entities or individuals authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.

Consent for ImPACT Testing and Release of Information

I give my permission for (name of child) _____ to have a baseline and post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) as needed, administered at Marshall High School. I understand that my child may need to be tested more than once post-concussion, depending upon the results of the test, as compared to my child's baseline test, which will be on file at Marshall High School. I understand there is no charge for the testing.

Marshall High School may release the ImPACT results to my child's primary care physician, neurologist, team physician or other treating physician, as indicated below.

I understand that general information about the test data may be provided to my child's school nurse, guidance counselor and teachers, for the purposes of providing temporary academic modifications, if necessary.

_____	_____	_____
Print Student-Athlete's Name	Signature of Student-Athlete's Name	Date
_____	_____	_____
Print Parent/Guardian Name	Signature Parent/Guardian Name	Date