BERWICK AREA SCHOOL DISTRICT
500 LINE STREET
BERWICK, PENNA. 18603

TELEPHONE 570-759-6400

Wayne D. Brookhart
Superintendent

Renee Gomez
Business Administrator

Dear Parent/Guardian,

All student-athletes are required to complete and return the following RELEASE form before participating in athletics within the Berwick Area School District. This form helps to ensure that we comply with the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA law was put in place to ensure the confidentiality of individuals requiring medical care. By federal law, Certified Athletic Trainers must have a signed authorization form permitting us to disclose protected health information about the student-athlete to the coaching staff. Including the injury specifics, the severity of the injury, and the athlete's return-to-play status. For your son/daughter to participate in athletics, a copy of this form will need to be on file with the school's Athletic Trainer. This form will only need to be completed one time per year, before the start of the sports season. Please be sure to fill in the highlighted areas including Patient Name, Patient/Athlete Signature, Parent/Guardian Signature, and dates. This form should be turned in to the head coach of your son/daughter's sport.

Also, it is important to make sure that all forms for athletic participation are completed in full (with a pen) and are easy to read. Please be sure to note that PIAA rules require every athlete to turn in a completed physical to the coaching staff before the first practice and that the official PIAA 6-page form is the only form of the physical exam that can be accepted. This form can be found on the athletics page of the school website or at www.piaa.org by clicking on resources, then forms, and select PIAA CIPPE form section(s) 1-9.

New for the 2015-2016 school year is the addition of a second Certified Athletic Trainer to the Berwick Area School District. This Athletic Trainer will provide coverage only on days when multiple athletic events are going on at the same time. To ensure that our athletes are receiving the necessary care at the time of injury. All injuries reported to the full-time Athletic Trainer for further evaluation and treatment as needed. If you have any questions, please feel free to contact me at Ext. 3250 of the middle school or at mhertz@berwicksd.org.

Sincerely,

Matthew Hertz, ATC
Geisinger Sports Medicine
Berwick Area School District

AUTHORIZATION TO
RELEASE
ATHLETIC MEDICAL INFORMATION

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

• GEISINGER EMPLOYEE USE ONLY •

[X] Geisinger Medical Center 100 N. Academy Avenue Danville, PA 17822	[X] Geisinger Wyoming Valley Medical Center 1000 E. Mountain Boulevard Wilkes-Barre, PA 18711	[X] 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.**

Berwick 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 _____06/01/15_____ to ____06/01/16_____

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**..0

–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.
_____	_____	My evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation and/or neuro-psychological information may be released to the recipient noted above.
_____	_____	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*