CPRS Physical Therapy Hands that heal. Hearts that care.

HIPAA PRIVACY AUTHORIZATION FORM

AUTHORIZATION FOR USE OR DISCLOUSRE OF PROTECTED HEALTH INFORMATION

Student Name _____ Birth date _____

I hereby authorize Central PA Rehabilitation Services, Inc. (CPRS Physical Therapy) to release individually identifiable health information related to my health, athletic injury, treatment, training or safety that impacts my ability to participate in interscholastic athletics to the family/school/team physician, school nurse, coaching staff (including head coaches and assistant coaches), athletic director, school principal(s), EMS personnel and such persons as needed for them to provide consultation, treatment and establish a plan of care.

SPECIAL AUTHORIZATION (if applicable)
I hereby authorize CPRS Physical Therapy 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	_____ Student	Evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released.
_____ Parent/Guardian	_____ Student	Evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation and/or neuropsychological information may be released.
_____ Parent/Guardian	_____ Student	Testing, diagnosis or treatment for HIV/AIDS may be released.

The protected health information used or disclosed in accordance with this authorization could be redisclosed by the recipient upon transfer to another school district and no longer protected by the privacy policies of CPRS Physical Therapy or the requirements of the Health Insurance Portability and Accountability Act of 1996.

I understand that this Authorization is in effect for a period of the current scholastic sport season or beyond in the event of the continued treatment of an injury from that designated sports season.

I understand that this Authorization is also in effect if I am treated for an injury during off-season workouts.

This Authorization is valid until and will expire on _____.

I understand that, to revoke this authorization prior to the expiration date, I must send a written notice to CPRS Physical Therapy at 75 Evelyn Drive, Millersburg, PA 17061 confirming the revocation and specifying an effective date.

I understand that my decision to revoke the Authorization does not apply to any release of health information that may have taken place prior to the date of my request to revoke this Authorization.

I understand that I am entitled to a copy of this completed Authorization form.

My signature below acknowledges that I have read this Authorization for Disclosure of Protected Health Information/Athletic Medical Information.

_____ _____
Athlete Signature Date

_____
Parent or Legal Guardian Printed Name

_____ _____
Parent or Legal Guardian Signature Date