

CUMBERLAND VALLEY HIGH SCHOOL

6746 Carlisle Pike • Mechanicsburg, PA 17050-1796
717-697-8261

AUTHORIZATION TO DISCLOSE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Name of Student: _____
First Name Middle Initial Last Name

We, the above-named student (the “Student”) and the parent(s)/legal guardian of the Student understand that as a condition of participation in the extracurricular activities at Cumberland Valley School District (the “District”) every student of the District must consent to random drug testing, and any necessary repeat of follow-up testing to detect the illegal use of drugs. We understand that the random drug testing, and any necessary repeat of follow-up testing, will consist of the furnishing of a urine specimen which will be tested by the Department of Laboratory Medicine of Geisinger Holy Spirit Hospital for the presence of amphetamines, barbiturates, benzodiazepines, cocaine, marijuana, methadone, methaqualone, opiates, PCP and propoxyphene, and at the District’s request, anabolic steroids and other performance-enhancing drugs (“Controlled Substances.”)

We hereby authorize the Department of Laboratory Medicine of Geisinger Holy Spirit Hospital and the physician serving as the Medical Review Officer (MRO) to report the results of the Student’s drug test to the Student, the Student’s parent(s)/legal guardian and the following employees of the Cumberland Valley School District:

- The Superintendent and Assistant Superintendent
- The Student’s Building Principal
- The Student Assistance Team
- The Athletic Director, Coach, Program Director and Faculty Supervisor who supervises the student’s participation in the athletic team, extra-curricular activity or co-curricular activity, as the case may be.

We further authorize the Department of Laboratory Medicine of Geisinger Holy Spirit Hospital and the physician serving as the MRO to report to the above-listed persons the results of any repeat drug testing necessary due to specimen quality and the results of any follow-up testing to confirm a positive drug test or to confirm drug free status following entry into a drug assessment or drug treatment program.

The purpose of the reporting of the Student's drug test results to the Student, the Student's parent(s)/legal guardian, and the above-named employees of the District is to enforce the District policy that students participating in athletics, students participating in extracurricular and co-curricular activities, and students with driving privileges, be drug free, and to facilitate placement of students who test positive participate in a drug assessment of drug treatment program. This Authorization shall expire on the earlier of the date of the signing by the Student and the Student's parent(s) or legal guardian of another Authorization to Disclose Individually Identifiable Health Information intended for the same purposes stated in the Authorization, the date on which the Student's enrollment as a student in the District terminates or one (1) year from the date of this Authorization.

We understand that we have the right to revoke this Authorization by delivering to the Administrative Director of the Department of Laboratory Medicine of Geisinger Holy Spirit Hospital, 503 North 21st Street, Camp Hill, Pennsylvania, 17011 a written statement stating our intent to revoke this Authorization. We also understand that our revocation will be effective immediately upon its receipt by the Administrative Director of the Department of Laboratory Medicine of Geisinger Holy Spirit Hospital. We further understand that if we refuse to sign this Authorization, or if we revoke this Authorization, the Student will not participate in any drug testing and, therefore, will not be eligible for participation in the District's athletic program, extracurricular or co-curricular program, or for the driving privileges, for which the testing was required.

We understand the disclosure from Geisinger Holy Spirit Hospital to the Student, the Student's parent(s)/legal guardian and the employees of the School District is subject to the privacy requirements of the regulations issued under the Health Insurance Portability and Accountability Act ("HIPAA"), 45 C.F.R. Part 164, Subpart E (Privacy of Individually Identifiable Health Information,) and is therefore subject to disclosure only as set forth in the notice of privacy rights which we received along with this Authorization. We understand that after the information about the Student is disclosed by Geisinger Holy Spirit Hospital to the District and ourselves, it is no longer protected by the HIPAA regulations from redisclosure by the District or ourselves to other parties. However, the District and Geisinger Holy Spirit Hospital have agreed that the District will not disclose the results of any Student's drug test to any persons except those identified in this Authorization

We hereby acknowledge that we have received a signed copy of this Authorization, and we have received a copy of Geisinger Holy Spirit Hospital's Notice of Privacy Practices.

Date

Student Signature

Date

Parent(s)/Legal Guardian (Please circle applicable term)

Date
