Big Sky Medical Center

AUTHORIZATION AND RELEASE FOR USES & DISCLOSURES
OF PROTECTED HEALTH INFORMATION (PHI)
FOR EXTRACURRICULAR ACTIVITIES DRUG-TESTING PROGRAM

Section A: This section must be completed for all Authorizations		
I authorize Big Sky Medical Center to use or disclose specific information (described below) about my medical condition to Big Sky School District #72. The protected health information to be used or disclosed is described in detail below.		
Student/Patient name: (Please Print)	Birth Date:	SSN (optional):
Student/Patient Address:		
Description of information to be used or disclosed		
Drug use test results, as performed in accordance with the Big Sky School District #72 Extracurricular Activities Drug-Testing Program		
Purpose of the use or disclosure		
Drug use test results (detailed above) to be disclosed to Big Sky School District #72 as part of their Student Activity Drug Testing Policy.		
I hereby authorize the use and disclosure of the above described PHI for the purpose and extent stated above. Unless I choose to revoke this authorization, this Authorization will remain in effect for the entire high school career (grades 9-12) and will expire upon completion of the entire high school career.		
I understand that: 1. I may refuse to sign this authorization and that this authorization is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details regarding how to revoke may be found in the Notice of Privacy Practices. 4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, if I ask for it. 6. I get a copy of this form after I sign it.		
Section B: Signatures		
I have read the above and authorize the disclosure of the protected health information as stated.		
Student Signature:	Date:	
Parent/Guardian Signature:	Date:	