



**Dulaney High School**  
Athletic Department  
255 PADONIA ROAD  
TIMONIUM, MARYLAND 21093

**H.I.P.A. Form**

Release of medical Information Authorization

*In accordance with the standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following provides for the release of medical information to the appropriate listed personnel.*

This is to authorize the release of medical information, to or between, the Dulaney High School Department of Athletics Division of Sports Medicine (i.e. Dulaney Certified Athletic Training Staff, Baltimore County Team Physician Staff, and consulting physicians), coaching staffs, and the Administrative Athletic Department personnel concerning injuries or illnesses relating to my participation in athletics, past, present, or future, at Dulaney High School.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student's Name - Printed

\_\_\_\_\_  
Sport(s)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Social Security #

\_\_\_\_\_  
Parent/Guardian (if under 18yrs old)

**The following information is for the sole purpose of assisting the Athletic Trainer in coordinating appointments between parents, students and physicians.**

*Please complete ALL of the following information*

**DULANEY HIGH SCHOOL  
EMERGENCY INFORMATION FOR INTERSCHOLASTIC ATHLETICS**

PLEASE PRINT

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Parent / Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_

Father's Phone during Day \_\_\_\_\_ Mother's \_\_\_\_\_

*In an emergency, if parents cannot be contacted:*

Notify \_\_\_\_\_ Phone No. \_\_\_\_\_

Family Doctor \_\_\_\_\_ Doctor's Phone \_\_\_\_\_

Preferred Hospital \_\_\_\_\_ Known Allergies \_\_\_\_\_

The team physician, trainer and coach may apply first aid treatment until the family doctor can be contacted  Yes  No. We give our consent for coaches, trainers and team physician to use their judgment in securing medical aid and ambulance service in case the parents cannot be reached  Yes  No.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**Student Insurance Information**

Name of Insurance \_\_\_\_\_

Policy and Group Number \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Policy Holder's Social Security Number \_\_\_\_\_

Is a Referral Required? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, Primary care physician's name and telephone number

\_\_\_\_\_