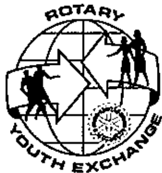

District 6110

Applicant Name	

Long-Term Exchange Program

Authorization for Release of Health Information

The undersigned APPLICANT and his/her PARENTS or LEGAL GUARDIANS hereby authorize any physician, dentist or other medical professional that the APPLICANT has seen within the past two years to release information to and/or consult with any Rotary-authorized personnel, for the purpose of providing additional information related to any medical condition that might be pertinent to the APPLICANT'S success as an exchange student.

This authorization is in effect until 1) the APPLICANT returns from his/her exchange, or 2) is notified that he/she is not accepted into the Rotary Youth Exchange program.

I give my consent and authority for Rotary Youth Exchange to take action to help insure the safety, health, and welfare of my child. I also request and empower Rotary Youth Exchange to authorize medical personnel and hospitals to provide appropriate medical care, including but not limited to hospital tests, emergency surgical care, pathology, radiology and anesthesia, surgery and prescriptive drugs for the health of my child. I further authorize these individuals to serve as my child's HIPAA (Health Insurance Portability and Accountability Act) Personal Representative (or its equivalent) for purpose of receiving medical information and communicating with medical providers about my child's medical condition.

The child covered by this authorization is:

Applicant's Full Legal Name		Gender	Date of Birth (e.g., 01/Jan/1999)
		☐ Male ☐ Female	
Address — Street			
City	State/Province	Postal Code	Country
Home Phone	Mobile Phone	E-mail	

In Case of Emergency during the Youth Exchange contact:
Parent/Legal Guardian Information

Full Name of Father/Legal Guardian				Full Name of Mother/Legal Guardian			
Address — Street				Address — Street			
City	State/Prov.	Postal Code	Country	City	State/Prov.	Postal Code	Country
E-mail				E-mail			
Home Phone	Mobile Phone			Home Phone	Mobile Phone		
Occupation				Occupation			
Business Phone	Fax			Business Phone	Fax		

The undersigned APPLICANT and his/her PARENTS or LEGAL GUARDIANS have read this authorization to provide medical information and treatment, know the contents thereof, and the statements contained in it are true to the best of our knowledge and belief.

Applicant (print name)	**Father/Legal Guardian** (print name)	**Mother/Legal Guardian** (print name)
Signature	**Signature**	**Signature**
The foregoing document was acknowledged before me by _____________________ (Parent or Guardian), who is known to me personally or who has produced satisfactory evidence of identification to me.	**The foregoing document was acknowledged before me by _____________________ (Parent or Guardian), who is known to me personally or who has produced satisfactory evidence of identification to me.**	**The foregoing document was acknowledged before me by _____________________ (Parent or Guardian), who is known to me personally or who has produced satisfactory evidence of identification to me.**
Notary Public	**Notary Public**	**Notary Public**
Signature	Signature	Signature
Dated this ____________ Day of __________________ Month, _________________________ Year.	Dated this ____________ Day of __________________ Month, _________________________ Year.	Dated this ____________ Day of __________________ Month, _________________________ Year.

Rotary-Authorized Personnel (to be filled in by the Rotary-authorized personnel)

Name (type or print)	**Signature** (in blue ink)	**Date** (e.g., 01/Jan/2006)
address, phone, and fax (type or stamp)		

Rotary Youth Exchange Officer (to be filled in by the RYE Officer)

D6110 Co-YE Officer's Name (type or print)	**Signature** (in blue ink)	**Date** (e.g., 01/Jan/2006)
YE Officer's address, phone, and fax (type or stamp)		

revised 8/24/2016