

Millersville University Intercollegiate Athletics

Athletic Training

Sickle Cell Information

Beginning in the 2022-2023 academic year the NCAA requires that all new student-athletes submit proof of sickle cell status. Opting out of the test and signing a waiver is no longer an option. Millersville University Athletic Trainers must have proof of the student-athlete's sickle cell status on file before that student is medically cleared for athletic participation. Anyone born in the United States after 2001 was sickle cell tested at birth. Sickle cell status can be obtained one of three ways. **Please note that each method does take time to complete. It is recommended that student-athletes start this process ASAP to avoid any delays in the clearance process.**

Option 1: Request your sickle cell status from the department of health from the state you were born in.

- Complete the appropriate form/process for the state you were born in.
- Results can be faxed directly back to: Millersville University Athletic Training, 717-871-7885
 - Delaware: Not available from department of state to patients must be requested by the patient's primary care provider. See Option 2
 - New Jersey: Not available from department of state to patients must be requested by the patient's primary care provider. See Option 2
 - New York: Not available from department of state to patients must be requested by the patient's primary care provider. See Option 2
 - Maryland: Contact Sickle Cell Disease Follow-Up Program at 410-767-6737
 - Pennsylvania: Follow instructions on attached PA form
 - Virginia: Follow instructions on attached VA form
 - If your state of birth is not listed contact that state's health department for more information.

Option 2: Request your sickle cell status from your primary care physician

- Contact your primary care physician.
- Ask for your sickle cell status or results of your newborn blood tests.
- Have results faxed to Millersville University Athletic Training, 717-871,7885

Option 3: Be tested for sickle cell status

- Contact your primary care provider. Inform them that you need your sickle cell status for participation in collegiate athletics.
- They will write a script for a hemoglobin solubility or hemoglobin iontophoresis test.

- Have results faxed to Millersville University Athletic Training, 717-871-7885

Authorization to Obtain Newborn Screening Results and for Disclosure of Protected Health Information

The DEPARTMENT OF HEALTH may take up to three business days to fulfill the request.

1. I authorize the Pennsylvania Department of Health (Department) to use/disclose individual newborn screening information/results obtained from the records of: (Please Print)

Name at Birth: _____

Date of Birth: _____ Sex: M F

Telephone: _____

Address: _____

Hospital of Birth: _____

Mother's Full Name: _____

Mother's Maiden Name: _____

Last 4 digits of Mother's Social Security Number: _____

2. Reason for disclosure of Department Newborn Screening Results:(Describe each specific purpose – such as: use for direct patient care or college application)

3. I understand that:

- a. This authorization may be revoked at any time by writing to the Department except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.
- b. The Department will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.
- c. Information disclosed pursuant to this authorization may be subject to re-disclosure by the organization identified in section below and is no longer protected by federal privacy regulations.
- d. The Department, its programs, services, employees, officers, and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.
- e. I may refuse to sign this authorization.

4. This information is to be disclosed to:

Name or title of the organization: Millersville University

Fax number where results will be sent: 717-871-7885

5. This authorization expires when results have been obtained.

Signature of Parent/Guardian, Individual or Personal Representative Date

If personal representative, state relationship to individual: _____

Signature of Witness Date

Commonwealth of Virginia
Department of General Services
Division of Consolidated Laboratory Services
Richmond, Virginia

Authorization and Consent Release-Hemoglobinopathy

SECTION 1: Patient Information at the time of testing

(Please print):

_____	_____	_____			
First Name	Last Name	Middle Initial			
Male _____ Female _____	_____	_____			
Sex (Circle one)	Date of Birth	Phone number (XXX-XXX-XXXX)			
_____	_____	_____			
Current Address Street, Apt. #	City	State	Zip Code		
_____	_____				
Hospital of Birth	Physician of Record at the Time of Collection/Concern				
_____	_____	_____			
Mother's Last Name at Birth	First Name	Middle Name or Initial			
_____	_____	_____			
Mother's Address at Birth	Street	Apt. #	City	State	Zip Code

SECTION 2: Authorization of Release:

I hereby authorize the Department of General Services, Division of Consolidated Laboratory Services, Richmond Virginia, 23219, to release, disclose and deliver the result(s) indicated above. **Please be aware this request may take up to thirty days to process and deliver.**

Send report to:

Disclaimer:

Using the standard initial screening methodology of isoelectric focusing (IEF), this laboratory can presumptively identify the following major hemoglobin (Hb) bands: F, A, S, D, C, E, and hemoglobin Bart's. Subsequent HPLC methodology permits quantification of the abnormal Hb variants. The normal hemoglobin pattern in a newborn is FA. Hemoglobin bands other than the ones listed above will be reported as FAV with "V" designating an unidentified band. While the sensitivity of IEF and HPLC are excellent, result and their interpretation can be compromised by extreme prematurity or previous blood transfusions. If further information is required regarding these results, please contact your physician.

Re-disclosure:

This release does not authorize re-disclosure of medical information beyond the limits of this consent. The recipient of this information is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party without further authorization. I therefore understand this is a one-time authorization.

SECTION 3: Validity: I authorize the release of information as indicated above

Date	Patient Name (<i>Print</i>)	Signature
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Date	Parent/Guardian /Power of Attorney (<i>Print</i>)	Parent/Guardian/Power of Attorney (<i>Signature</i>)
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Note (Power of Attorney): If signing as the Power of Attorney, please provide a copy of the signed legal documentation providing authority as the Power of Attorney for the patient noted on this authorization and consent release form.

SECTION 4:

Given under my hand and seal of office this _____ month, day of _____, _____ (year)

Notary Public's Signature

(Personalized Seal):

If a notary is unavailable, you may send a photocopy of your driver's license as proof of your identity.

This area is for Data Entry/IT Support Group's use only:

<u> </u>	<u> </u>	<u> </u>	<u> </u>
Date Received	Initials	Date Processed	Initials

Comments:

Hemoglobinopathy Consent Form – Medical Records

Hemoglobinopathy-Authorization and Release-Instructions

SECTION 1:

- **Patient Information at time of testing:** Use this section to indicate information about the patient whose records are being sought. DCLS will use this information to query our records, so please be specific and detailed.

SECTION 2:

- **Laboratory Report type(s):** Use this section to specify what type of laboratory report you are requesting or what type of testing was performed. Examples of tests: tuberculosis, newborn screening, or influenza.
- **Approximate specimen collection date:** Use this section to approximate the date your specimen was collected and sent to DCLS. A range of dates can be entered.
- **Send report to:** Use this section to specify where you would like the copy of the report(s) sent.

SECTION 3:

- **Validity.** The patient or designee *must* sign the request form. Forms that are not signed will not be processed.
- **Power of Attorney:** Legal documentation proving power of attorney for the patient **must** accompany the request form.

SECTION 4:

- **Notary Section:** Have the request form notarized. If a notary is unavailable, you may send a photocopy of your driver's license as proof of your identity.

Once completed, send the form to:

Division of Consolidated Laboratory Services
Attention: Patient Report Requests
600 North 5th Street
Richmond, Virginia 23219

Consent Form – Medical Records C