Exhibit E

CentegraHealthSystem

General Consent and Acknowledgement and Authorization of Disclosure of Protected Health Information

CONSENT FOR MEDICAL TREATMENT

I,_____(Please PRINT Student name), _____, (Parent or Guardian of said Student) consent to the procedures and tests required to obtain a urine sample from me/my child for purposes of the Harvard School District 50 random drug testing program. I understand that this consent will continue in effect for the duration of my/my child's status as a Student in Harvard School District 50. I understand that independent, third party providers which are not part of Centegra Health System, such as Quest Diagnostics, will participate in the acquisition and testing of the urine sample. I understand that such independent, third party providers are not employees or agents of Centegra Health System. I agree to follow the Patient Rights & Responsibilities of Centegra Health System. I have read and understand the above terms of this Consent and confirm that I am the Student **/Parent or Guardian of said Student**.

AUTHORIZATION OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that information obtained and/or created in connection with the acquisition and testing of my/my child's urine sample is protected health information which pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") may be disclosed **only** on my written authorization, except as required or permitted by law. I hereby authorize Centegra Health System to disclose the protected health information pertaining to the acquisition and testing of my/my child's urine sample to:

Principal or Designee
Harvard School District 50
Harvard, Illinois

I acknowledge that the disclosure of my/my child's protected health information pursuant to this Authorization is for purposes of my compliance with the random drug testing program of Harvard School District 50. I may inspect and arrange for photocopies of the protected health information that is to be disclosed pursuant to this Authorization. **THIS AUTHORIZATION EXPIRES at the conclusion of my/my child's status as a Student of Harvard High School Dist. 50.** I may revoke this Authorization at any time (except to the extent that action has already been taken in good faith reliance on this Authorization) by submitting a written revocation to Centegra Health System. If I refuse to sign this Authorization, my/my child's protected health information pertaining to the urine sample acquisition and testing will not be released. After signature by myself and a witness, I may take a copy of this Authorization for my/my child's personal records.

I understand that protected health information disclosed pursuant to this Authorization may be re-disclosed by the recipient and may not be covered by law. Centegra Health System is not responsible for any re-disclosures of protected health information. I agree to release and hold harmless Centegra Health System, its agents and employees from any liability that may arise from the use and/or disclosure and/or re-disclosure of my/my child's protected health information.

PATIENT CERTIFICATION

By signing this General Consent and Acknowledgement and Authorization of Use and Disclosure of Protected Health Information, I acknowledge that I have read and understand the information contained in this form and I accept its terms.

_____	_____	_____	_____
Student's: Parent or Guardian signature	**Today's Date**	**Student Graduation Year**	**Student Date of Birth**

Parent or Guardian's phone number:_____

_____**Witness**