

Release of Information Authorization

I, _____ (Student Athlete), authorize and request that the team physicians, certified athletic trainers, or other medical personnel of Jamestown College may receive information regarding my medical history as it may be requested by Jamestown College's Certified Athletic Trainers. Information authorized for such disclosure includes, without limitation, records pertaining to injury, surgery, serious illness and rehabilitation results.

I authorize the School Representative (Certified Athletic Trainer) to direct any information disclosed pursuant to this Release of Information Authorization only to the appropriate personnel of Jamestown College (Head Coach/ Athletic Director) or other inquires as directed by the student athlete.

The purpose of this disclosure is to respond to any and all requests for health information made by the parties named above for the purposes relating to the playing athletics at Jamestown College.

My signature below acknowledges that I have read this Authorization, understand my rights as described herein, and authorize release of my health information. I am providing this Authorization voluntarily. This Authorization shall expire when I finish my eligibility at Jamestown College or immediately following leaving Athletics at Jamestown College.

(PLAYER'S SIGNATURE)

(DATE)

If a personal representative signs this Authorization on behalf of the player, please complete the following:

Personal Representative's Name (Parent or Guardian): _____

You are entitled to a copy of this Authorization after you sign it. You have the right to revoke this Authorization at any time by written notification to the School Representative. This is part of the HIPPA Compliant Authorization