

Authorization for Release of Medical Records

To Whom It May Concern:

I hereby authorize Freed- Hardeman University Office of Student Health or any physician who has attended or examined me to release information with respect to my illness, medical history, consultations, prescriptions or treatments and copies of hospital or medical records to the Department of Athletics, Athletic Training Staff.

I hereby grant Freed-Hardeman University, Athletic Training Staff permission to release, if necessary, all information and records which relate to present and past medical history to the proper agencies; (insurance companies, doctors outside of FHU Athletic Training Staff, professional athletic teams, and coaching staff).

I understand that I may revoke this authorization at any time in writing. I also understand that any release which has been made prior to my revocation and which was made based upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization shall expire _____ .

Date

Witness

Athlete Signature

Date

Date

If the athlete is under age eighteen (18) or has a guardian appointed by the court, this release must be signed by the athlete's parent or guardian.

Parent or Guardian

Date

Witness

Date

**** Please note this is a blanket consent form for the entire year. You may cancel it at any time by notifying (in writing) the Athletic Training Staff.*