

Consent for release of information

I, _____, _____, _____, _____
Name Sport Date of Birth Social Security #

Do hereby grant authorization to the SUNY Brockport Sports Medicine Staff to release and /or obtain my injury reports and/or medical records and participation status for any and all injuries /illnesses incurred as a direct result of or affecting my participation as a member of an intercollegiate athletic team at SUNY Brockport. This information, as warranted and/or appropriate would be release to one or more of the following:

Athletic Administration
Hazen Health Center
Appropriate athletic team coach
Team physician
Family and/or specialist physician
Hospitals / clinics / ambulance crew
Insurance providers
Professional scouts
Parents

I understand that in accordance with Federal and State laws, this release does not include permission to transmit information specifically related to HIV (Human Immunodeficiency Virus) the causative agent of AIDS) status, and if such information is to be released, additional specific release forms are required. I understand that this consent is valid for 1 academic year from the date of signing and that I may rescind this consent at any time with written notification.

Student Signature Witness Date

Parent signature if student is under the age of 18 Date