



SMH 48 USM MR Authorization for Release of Medical Information

Student's name: _____ Date of Birth: _____
 Address: _____
 City/State/Zip Code: _____
 Home phone #: _____
 Date of Request: August 1, 2021 Date Needed: August 1, 2021
 Sports Team: _____ Grade: _____
 Varsity Junior Varsity Freshman Other: _____

<input checked="" type="checkbox"/> I authorize UR Sports Medicine to release information to: <div style="text-align: right; margin-right: 50px;"><u>School</u></div> Name of School _____ Address of School _____ City, State, Zip Code _____ Phone #/Fax# (include area code) _____	AND	<input checked="" type="checkbox"/> I authorize UR Sports Medicine to obtain information from: <div style="text-align: right; margin-right: 50px;"><u>School</u></div> _____ and <u>Student's Primary Care or Specialty Physicians</u>
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PURPOSE FOR THIS REQUEST:

Healthcare/Injury Prevention

TYPE OF RECORDS REQUESTED:

For any sports related injury treated by any UR Medicine-Sports Medicine athletic trainer during 8/1/21 - 7/31/22

AUTHORIZATION VALID FOR:

This request and for medical records of any future treatment of the type described above until: 7/31/22

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

Signature of Student: _____ Date: _____

Signature of Parent or Guardian (if Student is under age 18) _____

_____ Date: _____