UR | STRONG
MEDICINE | MEMORIAL HOSPITAL

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UR Sports Medicine
4901 Lac Deville Blvd.
Suite 110, Building D
Rochester, NY 14618
Phone: (585) 341-9200 Fax: (585) 340-9745

RR DONNELLEY

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, 2018 Date Needed: August 1, 2018

Sports Team: _____ Grade: _____

☐ Varsity ☐ Junior Varsity ☐ Freshman ☐ Other: _____

☒ I authorize UR Sports Medicine **to release information to:**

_____ **School**
Name of School

_____
Address of School

_____
City, State, Zip Code

_____
Phone #/Fax# (include area code)

AND

☒ I authorize UR Sports Medicine **to obtain information from:**

_____ **School**

and

Student's Primary Care or Specialty Physicians

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 **8/1/18 - 7/31/19**

AUTHORIZATION VALID FOR:

☒ This request and for medical records of any future treatment of the type described above until: **7/31/19**

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: _____

White – UR Sports Medicine Copy; Yellow – School Copy; Pink – Student Athlete Copy