

Authorization for Release of Medical Information

WCAA

Section A: Must be completed for all authorizations.

I hereby authorize the use or disclosure of my individual health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name: _____ SS number: _____

Persons/organizations providing the information: Person/organizations receiving the information:

WCAA/Western Carolina Athletic Association
P.O. Box 2077
Skyland, NC 28776

Specify description of information (including dates):

A full completed copy of the medical information contained on the WCAA Registration Form.

Section B: Must be completed for all authorizations.

The patient or the patient's representative must read and initial the following statements:

- I. I understand that this authorization will expire on (7/31/2011). Initials: _____
- II. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do so it will not have any affect on any actions taken before the revocation was received.
Initials: _____

Signature of Patient or Patient's Representative (Form MUST be completed before signing.)

Date

Printed name of Patient's Representative

Relationship to Patient

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information. Note well, this form is being provided to you in compliance with HIPPA; and other laws related to the release of Medical Information.