



Authorization for Release of Medical Information

August 2010

This form will allow WCAA's authorized agent to obtain medical information related to an athlete only in the event an injury occurs and a parent/guardian is not readily available to communicate with an emergency medical care provider.

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: _____

Person/organization receiving the information:

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

Specify description of information (including dates): medical information related to a sports injury which occurred on or about _____. (WCAA agent to fill in at time of accident.)

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.