

Temple University

Broad & Montgomery Ave. Philadelphia, PA 19122

TO WHOM IT MAY CONCERN:

I, _____, age _____,
while participating in the intercollegiate athletic program, representing
Temple University, expressly authorize the Temple University
Student Health Service, Temple University Hospital, Temple Sports
Medicine, and/or any other medical institution which might render
medical treatment to me during this period, to release the said
records to the Temple University Athletic Department, Team
Physician, Athletic Training Staff, Insurance Coordinator, or
Insurance Carrier in order that they will be better informed of my
medical condition and capabilities, while I participate in athletic
competition for Temple University. A photostatic copy of this
authorization shall be considered as effective and valid as the
original.

DATE: _____

NAME: _____

SIGNATURE: _____

SPORT: _____