Western Carolina University Intercollegiate Athletics
Consent for Release of Medical Records
2008-2009

I, ________________________________ **Age**, _______ : while participating in the
Print Your Name
Intercollegiate Athletic program representing Western Carolina University, expressly authorize the release of medical records, medical claims and insurance explanation of benefits from the Western Carolina University Student Health Service, Harris Regional Hospital, and any other Institution which might render medical treatment to me. The said medical records will be released directly to the Western Carolina University Athletic Department, Sports Medicine Director, Team Physician(s), Insurance Coordinator and its insurance carrier in order to better inform the related personnel of my medical condition(s), capabilities and progress as well as processing the payment of any medical claims for injuries that occurred while participating in the Intercollegiate Athletic Program at Western Carolina University.

A photostatic copy of this authorization shall be considered as effective as the original.

Athlete's Signature	Parent or Legal Guardian Signature
Date	Date
Social Security Number	Date of Birth
Sport	MR# **(For Office Use Only)**

INSURANCE INFORMATION RELEASE

Permission is granted to the Athletic Department of Western Carolina University to contact and receive information from my private insurance company described on the Insurance Notification form pertaining to payments, authorizations and/or action taken by my personal insurance company.

Athlete's Signature//Date	Parent/Legal Guardian Signature//Date