

**AUTHORIZATION FOR RELEASE OF  
MEDICAL INFORMATION**

**I, \_\_\_\_\_, HEREBY AUTHORIZE  
RELEASE OF ALL MEDICAL INFORMATION TO ALL TEAM  
PHYSICIANS AND MEMBERS OF THE ATHLETIC TRAINING  
STAFF OF FAIRMONT STATE UNIVERSITY. THESE MEDICAL  
RECORDS MAY BE USED TO HELP US FILE WITH OUR  
SECONDARY INSURANCE. MEDICAL INFORMATION IS  
NORMALLY CONFIDENTIAL AND, EXCEPT AS PROVIDED IN  
THIS RELEASE WILL NOT BE OTHERWISE RELEASED BY THE  
PARTIES IN CHARGE OF THE INFORMATION.**

**THIS RELEASE REMAINS VALID FOR ONE YEAR FROM THE  
DATE ORIGINALLY SIGNED.**

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Student-Athlete

\_\_\_\_\_

Date

\_\_\_\_\_

Parent / Guardian

\_\_\_\_\_

Date