

Clarkson University Athletic Training Medical Release Form

Name _____ DOB _____ Class Year _____ Team _____

I, _____, member of a CU sponsored varsity team, do hereby give permission to the employees of Clarkson University to share and release medical information in regards to my well-being. Team physicians, the sports medicine staff, and those deemed necessary are authorized to view and exchange information on my health and injury status. I realize that my medical records, including any and all information regarding my condition, may be shared. This may include my medical history, physical and laboratory findings, my diagnosis and treatment, and any limitations or restrictions regarding participation in CU athletics. I realize that my medical information may include sensitive information with regards to disease such as STD's. I also give permission to release my information for billing and insurance purposes. I understand that all information will only be shared for the purposes of treating my medical condition and paying my medical expenses incurred from an injury I receive while playing for a CU varsity sport. This release/consent remains valid for one year from the time of signing.

Patient Signature

Date

Guardian Signature if under 18

Date

