Sacramento State Athletics

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Student-Athlete _____
First Name Middle Last

Sport _____

Date of Birth _____ Social Security _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the above student-athlete to disclose all information with respect to any injury/illness, policy coverage, medical consultation, prescription or treatment to Department of Intercollegiate Athletics/Athletic Medicine.

A photocopy or faxed copy of the authorization shall be considered as effective and valid as the original. This authorization remains valid for one year after the date signed below.

Date _____ _____
Signature of Parent/Guardian
(if under 18 years of age)

Date _____ _____
Signature of Student-Athlete