

**CONFIDENTIAL MEDICAL RELEASE FORM**

Please release the following information to the person(s) or institution listed below.

\_\_\_\_\_Physical and Medical History Questionnaire

\_\_\_\_\_Insurance and Emergency Information

\_\_\_\_\_Report of Injury and Injury Treatment Records

\_\_\_\_\_All Medical Information

Please explain the purpose of the information that will be released at this time.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please explain any additional information that may or may not be released at this time.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please send the above information to: _____		
(Person(s) or Institution(s) Name)		
Address	State	Zip
Phone	Fax	

\_\_\_\_\_  
Athletes Name

\_\_\_\_\_  
Athletes Signature

\_\_\_\_\_  
Date