Waldorf University Department of Intercollegiate Athletics
Authorization to Release Information

Voluntary Participation: I affirm that my participation in athletic activities for and through Waldorf University is voluntary. I further affirm that my participation in the Waldorf University Drug Abuse Prevention, Education, Testing, and Counseling Program is voluntary.

Authorization to Share Medical Records: I authorize Drug Free Sport, located at 2537 Madison Ave., Kansas City, MO 64108, and its employees, doctors, technicians, and independent contractors to share with and/or release to Waldorf University, located at 106 S. Sixth St., Forest City, IA 50436, and its representatives, employees, business associates, and independent contractors, the following information: any and all medical records, including documentation of medical visits, tests performed, and results obtained, in connection with my voluntary participation in the Waldorf University Drug Abuse Prevention, Education, Testing, and Counseling Program.

I further acknowledge that Drug Free Sport may share with Waldorf University any and all information, medical records, documentation of medical visits, tests performed, and results obtained related to mental health treatment, substance abuse treatment, and/or HIV-related treatment.

Purpose of Disclosure: I understand that the disclosure that I authorize through this form will only be used in conjunction with the Waldorf University Drug Abuse Prevention, Education, Testing, and Counseling Program.

Right to Inspect: Any individual signing an Authorization to Release Information has a right to inspect disclosed mental health information at any time.

Right to Refuse: I understand that I may refuse to sign this form. I further understand that my refusal to sign this form will not affect my ability to obtain health care services.

Termination/Revocation of Authority: I understand that this authorization will terminate when my participation in the Waldorf University Drug Abuse Prevention, Education, Testing, and Counseling Program ceases. I further understand that I may revoke my consent to release my information at any time, in writing, and I understand that this revocation will be effective when received by the entity from which disclosure is sought.

Federal Privacy Warning: I acknowledge that the recipient of this medical information may not be covered by federal privacy regulations, and that such disclosure may be re-disclosed and will no longer be protected by regulations.

I specifically authorize and consent to the above disclosures including the disclosure of applicable mental health, substance abuse, and HIV-related treatment.

_____ _____

Signature of Patient (or legal representative of minor patient) *Date*

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Printed Name of Patient (or name and relation of legal representative of minor patient)

For reference to applicable law see: Iowa Code Sections 141A & 228, and 42 C.F.R. Part 2.