Sport and Performance Psychology Services

Authorization to Release or Disclosure of Health Information

To be completed by patient or patient's parent/guardian, if under the age of 18 years:

Patient's Name: ___________________________________

DOB:____________________________

I authorize the release of ____________________________ 's psychological and health information to those professionals who are actively involved in the athletic and academic affairs of the patient (e.g., Doctor's, coaches, athletic personal, learning specialists, and other support staff who work directly with the athlete).

I exclude the release and/or disclosure of this information to the following individuals:

Name: _____________________________
Name:______________________________
Name;______________________________
Name:______________________________

___________________________________ ________________________
Patient Signature Date

If under the age of 18 years:

___________________________________ ________________________
Parent or Guardian Signature Date