



MARS HILL COLLEGE SPORTS MEDICINE



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND PERMISSION TO TREAT

In the event I should be hospitalized, or receive treatment and care by facilities other than the Mars Hill College Campus Infirmary or by the Athletic Training Staff of the Sports Medicine Section of the Athletic Department, I do hereby authorize the release of any and all medical information and records from all Health Care Providers, Hospitals, Medical Clinics and Medical Specialists to my personal medical files located at the Student Health Services of the Campus Infirmary, and the Sports Medicine Section of the Athletic Department and allow access of such records and files to the Doctors, Nurses and Athletic Trainers of Mars Hill College.

I hereby give my permission to allow the Medical Doctors and Nursing Staff of the Campus Infirmary and the Sports Medicine Staff of Mars Hill College to treat me for injuries/illnesses I may encounter as a student/athlete at Mars Hill College.

Print Your Name Here _____ **Date** _____

Sign Your Name Here _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

(Parents/Guardians Must Sign If Student Is Under The Age Of 18)

COMPLETED FORM WITH SIGNATURES MUST BE RETURNED TO THE MARS HILL COLLEGE ATHLETIC TRAINING STAFF.