



Seminole Community College

Department of Athletics 56 / Athletic Training
100 Weldon Boulevard | Sanford, FL 32773-6199 | Phone: 407-708-2675 | FAX: 407-708-2142

Student-Athlete Private Health Information Release Form

TO ALL UNIVERSITIES, COLLEGES, HIGH SCHOOLS, STUDENT HEALTH SERVICES, CERTIFIED ATHLETIC TRAINERS, PHYSICAL THERAPISTS, OCCUPATIONAL THERAPISTS, PHYSICIANS, PHYSICIAN ASSISTANTS, HOSPITALS, CLINICS, DISPENSARIES, SANITARIUMS, HEALTH & AUTO INSURANCE PROVIDERS, AND OTHER RELATED HEALTH CARE AGENCIES:

You are hereby authorized and requested to send to and/or share with Seminole Community College's: Certified Athletic Trainers; Physical Therapists; Occupational Therapists; Physicians; and/or clinics (henceforth referred to as "SCC Sports Medicine"), a complete copy of all medical records pertaining to my medical condition, including all physical examinations; physician's records; Certified Athletic Trainer's records; musculo-skeletal rehabilitation records, diagnosis, treatment, history, and prognosis of any and all injuries / illnesses; and to receive from you any and all other information pertaining to my past and present medical condition, diagnosis, treatment, history, and prognosis from your personal knowledge and/or records. This authorization shall cover all past, present, and future medical conditions which might arise during my athletic participation with/at Seminole Community College. This authorization may be executed by SCC Department of Athletics / Athletic Training for a period of 30 months from the date of signature or for a period of 6 months following cessation of participation; whichever is longer. A photocopy, electronic or telecommunication reproduction of this authorization shall be considered as effective and valid as the original.

Student-Athlete's **Birth** Name: _____

Please Print Legibly: First, Middle, and Last Name

Student-Athlete's Date of Birth: _____ Social Security Number: _____ - _____ - _____

Student-Athlete: _____ Date: _____

Signature

Guardian signature and notary witness required if student-athlete is receiving health-benefits under the provisions of a health-benefits plan of the guardian or the student-athlete is not of legal age at the time of submitting paperwork.

Guardian: _____ Date: _____

STATE OF _____, COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ day of _____, _____, by

Signature of Notary Public

Print, Type or Stamp Commissioned Name of Notary Public

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____