



Authorization For Release of Information  
Reciprocal Disclosure

Name (Print) \_\_\_\_\_

Date of Birth \_\_\_\_\_

I hereby authorize the staff of the **Health Service Department of WCSU** to disclose any medical information regarding any illnesses, injuries or prior medical conditions which may affect my participation in the varsity sports program to the **Athletic Department of WCSU**.

In this reciprocal agreement, I also authorize the staff and team physicians of the **Athletic Department of WCSU** to disclose any medical information which may affect my participation in the varsity sports program to the staff of the **Health Service Department**.

By signing this authorization, I release the Health Service staff, the Athletic Department staff and team physicians and WCSU from any liability resulting from the release of this information.

I understand that unless withdrawn by me in writing, this authorization will expire one year from the date of authorization.

Signed \_\_\_\_\_

Date \_\_\_\_\_