Rutgers University
Robert Monaco, M.D., M.P.H.
Director of Sports Medicine
Hale Center
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Medical Release Form

I, _____, hereby give consent for my medical
(Print Name)
Records (office notes, operative Reports, discharge hospital summary) pertaining to the following problems which occurred on or around:

_____

to be **released** to Dr. Robert Monaco, Director of Sports Medicine at Rutgers University.

The information to be released is requested for continuing medical care of the patient. This authorization will expire six months from the date of the signature. You may revoke this authorization to release private health information at anytime. Your continued ability to get treatment and eligibility for benefits will not be affected by signing this document. By signing this document you also understand that there is potential for private health information to be re-disclosed by the recipient, and thus no longer protected under the privacy rules. All records are confidential. Records can be sent via fax or mail to the address noted above.

Signature of Athlete: _____ Date: ___ / ____ / ____

Social Security Number: _____ DOB ___ / ____ /_____

Sport: _____ Campus Phone: _____

_____

Recipient Name_____
(Doctor you are requesting records from)

Address: _____

City/State/Zip: _____

Phone: _____**Fax:** _____