



**2011/2012 EuroCrossCamp  
Authorization For The Release Of Information**

**Information Regarding the Use or Disclosure**

**I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.**

Participant Name \_\_\_\_\_ Last 4 SS# Digits: XXX-XX-\_\_\_\_\_

Persons/organizations authorized to provide the information include EuroCrossCamp ("ECXC"), USA Cycling Inc ("USA Cycling"), and my coach unless specified otherwise below, and: [below should list the athletes doctors]

---

---

---

Persons/organizations authorized to receive the information include EuroCrossCamp, USA Cycling, the United States Olympic Committee's Sports Medicine Division (staff and other agents), my coach, unless specified otherwise below, insurance carriers of the foregoing, and: \_\_\_\_\_

---

---

---

Specific description of information to be used or disclosed (including date(s)): includes all medical information, including sport science testing and evaluations (physiological, biomechanical, and psychological) which may impact my ability and eligibility to participate in the activities of EuroCrossCamp, USA Cycling and the United States Olympic Committee, unless specified to the contrary as follows: \_\_\_\_\_

---

---

---

Specific purpose of the disclosure (*note that "as requested by me" is an acceptable purpose if you do not wish to state a specific purpose*): To allow the evaluation of my ability and eligibility to participate in the activities of USA Cycling and the United States Olympic Committee, unless otherwise specified as follows: \_\_\_\_\_

---

---

---

This authorization will expire one year from the date hereof unless otherwise indicated as follows: (indicate date, or an event relating to you personally or to the purpose of the authorization) \_\_\_\_\_

---

---

---

**Important Information Regarding Your Rights**

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity and may no longer be protected by federal or state law. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.

**I have read this Authorization for Release of Information, fully understand its terms, and sign it freely and voluntarily without any inducement.**

Participant's Signature \_\_\_\_\_

Print name \_\_\_\_\_ Date \_\_\_\_\_

**FOR ATHLETES OF MINORITY AGE  
(UNDER THE AGE OF 18 AT THE TIME OF REGISTRATION)**

This is to certify that I/we as parent(s)/guardian(s) with legal responsibility and authority for this Athlete, do consent and agree not only to his/her authorization, but also for myself/ourselves, and my/our heirs, assigns and next of kin to authorize such release of information

Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_