



**WILLIAM
PATERSON
UNIVERSITY**

COUNSELING, HEALTH & WELLNESS CENTER
OVERLOOK SOUTH
(973)-720-2360 • (973)-720-2257 • FAX: (973)-720-2632
300 POMPTON ROAD • WAYNE, NEW JERSEY 07470-2103 • WWW.WPUNJ.EDU

Student Athlete Request and Authorization to Release Records and/or Information

This form when completed and signed by you authorizes the Counseling, Health and Wellness Center and the Directors of Athletics, Athletic Coaches, Athletic Training Staff and Athletic training students, Directors of Club Sports, & Club Sports Advisors & Coaches, to release protected information from your clinical record to the person or agency you designate.

I authorize the Counseling, Health and Wellness Center clinical and administrative staff and the Directors of Athletics, Athletic Coaches, Athletic Training Staff and Athletic training students, Directors of Club Sports, & Club Sports Advisors & Coaches to release information to one another regarding my athletic physical and any relevant information related to participation in athletics & club sports at William Paterson University.

The records are to be discussed verbally, via fax, or via email for the purpose of coordination of care.

This authorization shall remain in effect for one year from the date indicated below or until (fill in expiration date/event): _____.

I understand that I have the right to revoke this authorization in writing, at any time by sending or delivering such written notification to the Counseling, Health and Wellness Center. However, my revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

Print Name

DOB

Signature of student/parent if minor

Date