

MEDICAL RECORDS RELEASE

I agree that my medical records shall be made available to the Northwood University Athletic Trainer during my athletic participation at Northwood University. I understand that my medical records will only be needed if an event arises that calls for the use of my medical records, medical emergencies, or if requested by the team physician.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

WITNESS: _____



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