WERA NATIONAL ENDURANCE SERIES

WERA Motorcycle Roadracing

Bike#_____

Team ID#_____

Tran#_____

Please Print Legibly Track _____ Date _____

Team Name _____ Address _____

City _____ State _____ Zip _____ Phone # ( ) _____-_____

Team Captain_____ Team Owner_____

Sponsor(s) _____

_____

Frame #1_____Frame #2_____Frame #3_____

Team E.I.N. or Team Owner SS#_____-_____-_____

Rider Name	Hometown/State	WERA ID#/Exp. Date	Emergency Contact	E.C. Phone#
1)_____	_____/____	_____/_____	_____	(____)_____-_____
2)_____	_____/____	_____/_____	_____	(____)_____-_____
3)_____	_____/____	_____/_____	_____	(____)_____-_____
4)_____	_____/____	_____/_____	_____	(____)_____-_____
5)_____	_____/____	_____/_____	_____	(____)_____-_____

Class_____ **Motorcycle Brand**_____ **Displacement**_____

Total Race Fees _____	Credit Card Number:_____	Cash _____
Misc./Practice _____	Cardholder Name:_____	Check _____
Membership _____	Signature:_____	Charge _____
		Credit(s) _____
Total Fees _____	Exp Date:_____	**Total Collected** _____

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I hereby consent to the disclosure of information from the patient health care records of the above rider to WERA Motorcycle Roadracing, or their representatives, for the purpose of their analysis and use.

This consent is for the disclosure of all patient health care records whose confidentiality is protected by Federal laws, as defined in 45 CFR § 164.508 (HIPAA Authorization Requirements for Release of Protected Health Information), 42 CFR Part 2 (Federal Requirements for Release of Alcohol and/or Drug Abuse Program Records), 38 CFR Part 1 (Release of HIV/AIDS, Sickle Cell Anemia, Drug Abuse, Alcoholism or Alcohol Abuse Records by the Department of Veteran Affairs), and Secs. 146.81and 51.30, Wis. Stats. These records include reports and findings relating to care, evaluation, testing, history, progress, diagnosis, prognosis and treatment, including summaries, team conference reports, medical, surgical, pathological, psychiatric, psychological, pharmaceutical, school, vocational, social service, and day service reports. I understand that information disclosed may include reference to or treatment for alcohol/drug abuse, HIV/AIDS and sickle cell anemia diagnoses, and/or emotional illness or developmental disabilities. Records of child and adolescent patients may include reference to parental emotional illness, including the treatment of alcohol and drug abuse.

I understand that any HIV/AIDS, sickle cell anemia information, and/or alcohol abuse/treatment information records cannot be redisclosed without my express written consent or as otherwise permitted by 42 CFR Part 2 or 38 CFR Part 1. A general authorization for the release of medical or other information is not sufficient for this purpose.

I further agree that a photostat copy of this consent shall be considered as effective and as valid as the original. It is my specific intention that this informed consent and request shall be effective for a period of two (1) years or until completion of the purpose for which this consent was given, unless this consent is specifically withdrawn by me in writing. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon this authorization and release of medical records. I also understand that I have the right to refuse to sign this authorization and release of medical records. I understand I may inspect and receive a copy of the disclosed information. I have read all of the above and understand the nature of this release and certify that it accurately reflects my wishes.

Rider Signatures: _____ _____

_____ _____ _____