



# WERA SPRINT MASTER ENTRY FORM

## WERA Motorcycle Roadracing

Bike # _____	Status _____
I.D. # _____	
Exp. Date _____	
Transponder # _____	

Please Print Legibly Track \_\_\_\_\_ Event Date \_\_\_\_\_ Comp# \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_

Sponsor(s) \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ E.C. Phone ( ) \_\_\_\_\_

Class	Brand/cc	Fees	Class	Brand/cc	Fees
A Superstock	_____	_____	Heavyweight Solo 20	_____	_____
B Superstock	_____	_____	Mediumweight Solo 20	_____	_____
C Superstock	_____	_____	Lightweight Solo 20	_____	_____
D Superstock	_____	_____	350 GP	_____	_____
E Superstock	_____	_____	500 GP	_____	_____
Heavyweight Twins SS	_____	_____	Vintage 1	_____	_____
Lightweight Twins SS	_____	_____	Vintage 2	_____	_____
Senior SB - HW MW	_____	_____	Formula 500	_____	_____
Formula 1	_____	_____	Vintage 3	_____	_____
Formula 2	_____	_____	Vintage 4	_____	_____
125cc GP	_____	_____	Formula 2stroke	_____	_____
Clubman	_____	_____	Vintage 5	_____	_____
Heavyweight Twins SB	_____	_____	Vintage 6 LW HW	_____	_____
Lightweight Twins SB	_____	_____	Vintage 7 HW	_____	_____
A Superbike	_____	_____	Vintage 7 MW	_____	_____
B Superbike	_____	_____	Minis - 80cc 50cc	_____	_____
C Superbike	_____	_____	Other/Practice	_____	_____
D Superbike	_____	_____			

Total Race Fees _____	Credit Card Number: _____	Cash _____
Air Fence Donation _____	Cardholder Name: _____	Check _____
Membership _____	Signature: _____	Charge _____
Riders School _____	Exp Date: _____	Credit(s) _____
Transponder _____		Discount (subtract) _____
Total Fees _____		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. 146.81 and 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 (2) 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.

Signature \_\_\_\_\_ Registrar \_\_\_\_\_