Athletic Training: Medical Release Form

Date: _____

Athlete's Name: _____

Date of Birth: _____ Phone: _____

I hereby authorize Iowa Western Community College's department of Sports Medicine to release my medical record as indicated below to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Fax #: _____

Information to be released:

- ☐ Physical
- ☐ Doctor's Progress Notes
- ☐ Operative Report
- ☐ Other _____

_____ _____

Signature of Athlete Date

Athletic Training | Iowa Western Community College
2700 College Rd. Council Bluffs, IA 51503
PH: 800.432.5852 ext. 6846 | FAX: 712.325.3394