IDAHO ATHLETIC COMMISSION

CONTESTANT LICENSE APPLICATION

HIPAA AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____ authorize the Idaho Athletic Commission to release any of my medical information to the following:

☐ Any Physician in Idaho (List any exceptions) _____

☐ Any Emergency Medical Technician in Idaho (List any exceptions)_____

☐ Any Hospital in Idaho (List any exceptions)_____

☐ The Promoter (Promoter's name)_____

☐ A Relative (List name and Relation)_____

☐ Any Athletic Commission that is a member of the Association of Boxing Commissions (ABC) (List any exceptions) _____

The following people, not otherwise listed _____

I understand that this "HIPAA Authorization to Release Medical Information" will remain in effect 365 days from the date below. I also understand that I reserve the right to revoke the contents herein at any time during the period this form is valid and complete a new form.

Printed Name:_____ Signature:_____ Date:_____

Commission Rep:_____ Date:_____