NORTH COUNTRY COMMUNITY COLLEGE

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Please complete all sections of this form. It is not valid until complete.

Name ______________________________ SS# ________________________________

I, __________________________, hereby request and authorize the release of any and all of my academic and health-related information to the following identified parties:

Please identify the parties you are authorizing to receive information.

___	Coach	___	Insurance Carrier	___	Media
___	Trainer	___	Doctor	___	Recruiters
___	Hospital	___	NJCAA	___	NJCAA Region III
___	Other (please identify) ________________				

Expiration of Authorization: This authorization will remain effective for twelve (12) months from the date of signature unless you specify a different date or an event that will cause the expiration to expire.

I authorize the release of the above information.

Signature: ___________________________ Date: ______________

cc: Director of Athletics
Student Health File/Records Office
Student Permanent File/Records Office