

EXHIBIT B

RELEASE OF INFORMATION

HIGH SCHOOL/MIDDLE SCHOOL

(Please Print)

Athlete's

Name: _____

Date of Birth: _____ Year in School _____

Sport or Sports: _____

I hereby authorize the Capital Region Medical Center Athletic Trainers and/or Team Physicians to release information regarding the health status of myself (over 18 years of age) or my son or daughter to their coaches/athletic directors as it relates to their ability to participate in sports, including information regarding the care and treatment of their injuries and/or illnesses, their condition, the prognosis, for statistical reporting of sports injuries and to meet required MSHSAA (Missouri State High School Athletics Association) guidelines/protocols.

This release will be in effect for the period of time I/they participate in sports with _____ (School/Club Sports Team/PAL league) but for no longer than 4 years from date of signature.

I understand that I have the right to revoke this authorization, in writing, at any time, except for information required to meet MSHSAA guidelines/protocols. I understand that a revocation is not effective to the extent that any person as already acted in reliance on my authorization. I understand that Capital Region Medical Center will notify the coaches this authorization has been revoked.

Signature: _____ Date: _____

Relationship to Student if Signed on Behalf of Student Under the Age of 18