2014 Authorization for Release of Protected Health Information Form

Each Player is required to sign the 2014 Authorization for Release of Protected Health Information Form before the player is allowed to compete in the 2014 US Open. The form can be submitted in advance or completed on arrival at Player Registration. If you would like to submit the form in advance, please print, sign and return via fax to 914.696.4333 or via e-mail to james@usta.com.

Please note that players under the age of 18 will also require the signature of a parent or legal guardian.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that you, or your legal representative, consent in writing to the disclosure of your protected health information, including your medical records. Please read all statements on this form carefully, as it describes your rights regarding the use or disclosure of your protected health information that is subject to this authorization.

I, the undersigned, authorize any Doctor or Trainer that provides medical treatment to me during my involvement in the US Open to disclose to the US Open Tournament Referee, Grand Slam Supervisor, US Open Tournament Director, US Open Director Player Medical Services, USTA Chief Medical Officer, USTA Legal, and medical personnel from the US Open and the player's respective tour (ATP World Tour or WTA) (collectively, the "Covered Entities") the following protected health information: medical records and/or treatment logs that contain information with respect to any diagnosis, treatment and/or medical services provided to me during my participation in the US Open.

The protected health information and medical records covered by this authorization may only be used by the Covered Entities for continuity of medical care and determination whether I am ruled unable physically to compete pursuant to the Official Grand Slam Rule Book. This authorization will remain effective until the start of the 2015 US Open.

I understand that I have the right to revoke this authorization, in writing, at any time (except to the extent that the Covered Entities have acted in reliance upon this authorization) by sending notification by secured carrier to: Chief Legal Officer, USTA, 70 West Red Oak Lane, White Plains, NY 10604. I understand that a revocation will prevent the Covered Entities from further use or disclosure of my protected health information, but it will not retract the uses or disclosures that have already been made pursuant to the authorization.

I understand that: (i) the protected health information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law; (ii) I have the right to refuse to sign this authorization; (iii) the Covered Entities cannot condition my treatment based upon whether I sign this authorization; (iv) I have the right to inspect and copy the protected health information and medical records covered by this authorization upon request; and (v) I have the right to receive a copy of this authorization upon request.

This waiver further authorizes any Doctor or Trainer that provides medical treatment to me during my involvement in the US Open to share my protected health information as follows:

Leave a voice mail recording including my protected health information on my home/business/cell phone: ❑ Yes ❑ No

Permit the following individual(s) to receive information on my protected health information:

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Print Name | Signature of Applicant | Date

If under 18 years of age, signature of parent or legal guardian

Print Name | Signature of Parent or Legal Guardian | Date