



NAGVA

North American Gay Volleyball Association

MEDICAL RE-RATE REQUEST FORM

Player's Name: _____
(As appears in NAGVA database)

NAGVA #: _____

Email Address: _____

Phone Number: _____

Current Rating: AA / A / BB / B (circle one)	DECISION: <i>To be completed by NAGVA</i>	<input type="checkbox"/> Approved - New Rating: _____
		<input type="checkbox"/> Denied

The information below is freely disclosed for the purpose of a request to be re-rated due to a current medical injury or condition pursuant to NAGVA Rules & Regulations 2.04 (2009). This disclosure is made freely and voluntarily to the Director of Eligibility and NAGVA Board of Directors. I further understand that NAGVA will make every effort to keep such information confidential.

Player's Signature: _____ Date: _____

Please describe your request a re-rating pursuant to R&R Rule 2.04:
(extra sheets may be attached as necessary)

Waiver and Release of Liability: *By my signature, intending to be legally bound, hereby myself, my heirs, executor and administrators indemnify and hold harmless from all causes of action and waive and release any and all rights from claims for loss or damages suffered by me for any reason whatsoever, including negligence on the part of this organization, which may arise against NAGVA and its officers, representatives, successors, and assigns for any and all injuries suffered by me. Should any disclosure of the information submitted for the purpose of this requests to a third party or parties occur, I agree to release and hold harmless NAGVA and the individual members of the NAGVA Board, in both their capacity as Board Members and individually, for any alleged harm from any such disclosure. By signing this waiver, I verify that I am at least eighteen (18) years of age (or) that I am not yet eighteen (18) years of age but have obtained and will present the signature of my Parent or legal Guardian. In addition, I acknowledge that I will comply with the Rules and Regulations of NAGVA, including the NAGVA Code of Conduct.*

Player's Signature: _____ Date: _____

Medical Information Privacy Authorization Form

Authorization for Use or Disclosure of Health Information

1. I hereby authorize the **NAGVA Director of Eligibility** to use and/or disclose the health information described above to the **NAGVA Board of Directors**.
2. If I am disclosing HIV-related, alcohol or drug treatment, or mental health treatment information, NAGVA is prohibited from redisclosing such information without my written authorization unless permitted and/or compelled to do so under federal or state law, or by order of a court of competent jurisdiction.
3. This medical information may be used by NAGVA solely for the purposes of evaluating my request for a medical re-rate pursuant to NAGVA R&R 2.04.
4. This authorization shall be in force and effect for **three months** from the date of signing below, at which time this authorization expires.
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may not be protected by federal or state law and any inadvertent redisclosure by NAGVA or a member of the Board of Directors shall be deemed harmless.

Player/Member Signature or Parent/Guardian (if Under the age of 18)

Date

Print Name of Member/Player

Relation to Member/Player

Print Name of Parent/Guardian

Relation to Member/Player