AMA Road Race Grand Championship
Master Entry Form
WERA Motorcycle Roadracing

Bike #	Status
I.D. #	
Exp. Date	
Transponder #	
AMA Membership #	

Please Print Legibly Track _____ Event Date _____ Comp# _____

Name _____ Address _____

City _____ State _____ Zip _____ Phone # ( ) _____-_____

Sponsor(s) _____

Emergency Contact Name _____ E.C. Phone ( )_____

EXPERT

Class	Brand/cc	Fees
1000 Superstock		
600 Superstock		
LW Twins Superstock		
400 Superstock		
1000 Superbike		
600cc Superbike		
LW Twins Superbike		

NOVICE

Class	Brand/cc	Fees
1000 Superstock		
600cc Superstock		
LW Twins Superstock		
400 Superstock		
1000 Superbike		
600 Superbike		
LW Twins Superbike		

Other_____Brand/cc_____Fees_____

Practice_____Brand/cc_____Fees_____

Check one if it applies: Youth (14 or under)_____ Senior/Vet (40 or over)_____

Total Race Fees _____	Credit Card Number:_____	Cash _____
Membership _____	Cardholder Name:_____	Check _____
Transponder _____	Signature:_____	Charge _____
Total Fees _____	Exp Date:_____	Credit(s) _____
		Total Collected _____

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I hereby consent to the disclosure of information from the patient health care records of the above rider to WERA Motorcycle Roadracing, or their representatives, for the purpose of their analysis and use.

This consent is for the disclosure of all patient health care records whose confidentiality is protected by Federal laws, as defined in 45 CFR § 164.508 (HIPAA Authorization Requirements for Release of Protected Health Information), 42 CFR Part 2 (Federal Requirements for Release of Alcohol and/or Drug Abuse Program Records), 38 CFR Part 1 (Release of HIV/AIDS, Sickle Cell Anemia, Drug Abuse, Alcoholism or Alcohol Abuse Records by the Department of Veteran Affairs), and Secs. 146.81and 51.30, Wis. Stats. These records include reports and findings relating to care, evaluation, testing, history, progress, diagnosis, prognosis and treatment, including summaries, team conference reports, medical, surgical, pathological, psychiatric, psychological, pharmaceutical, school, vocational, social service, and day service reports. I understand that information disclosed may include reference to or treatment for alcohol/drug abuse, HIV/AIDS and sickle cell anemia diagnoses, and/or emotional illness or developmental disabilities. Records of child and adolescent patients may include reference to parental emotional illness, including the treatment of alcohol and drug abuse.

I understand that any HIV/AIDS, sickle cell anemia information, and/or alcohol abuse/treatment information records cannot be redisclosed without my express written consent or as otherwise permitted by 42 CFR Part 2 or 38 CFR Part 1. A general authorization for the release of medical or other information is not sufficient for this purpose.

I further agree that a photostat copy of this consent shall be considered as effective and as valid as the original. It is my specific intention that this informed consent and request shall be effective for a period of two (2) years or until completion of the purpose for which this consent was given, unless this consent is specifically withdrawn by me in writing. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon this authorization and release of medical records. I also understand that I have the right to refuse to sign this authorization and release of medical records. I understand I may inspect and receive a copy of the disclosed information. I have read all of the above and understand the nature of this release and certify that it accurately reflects my wishes.

Signature _____Registrar_____