# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the FSGA and their designated agents and FSGA medical panel professionals participating in the decision to determine my eligibility to play in FSGA Competitions to contact my health care provider(s) regarding my gender reassignment.

I authorize my health care provider(s) to communicate with the FSGA, their designated agents and FSGA medical panel professionals participating in the decision to determine my eligibility to participate in FSGA Competitions to provide such clarification or further information may be necessary for the FSGA to make a determination regarding my eligibility to play in FSGA Competitions. I authorize the release of any documentation, medical records, or other information relating to my gender reassignment.

_____

Signature

_____

Print Name Date