AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

AUTHORIZATION TO PHYSICIANS, HOSPITALS OR OTHER INSTITUTIONS

I hereby authorize _____ by this release, or a photocopy of it, to furnish the Nevada Athletic Commission with copies of any and all of my medical records, hospital records, or other information that it may request regarding conditions for which I have been under your observation or treatment, including any history, findings, diagnosis, or prognosis. I also authorize you to send those records to the Nevada Athletic Commission via facsimile to 702-486-2577, upon the Commission's request. The purpose of this release is for continued patient care and evaluation.

You are further authorized, should it be requested, to give the Nevada Athletic Commission an oral report, by telephonic communication, as to my medical condition, care, or treatment. This authorization shall remain effective for one year from the date signed, and is intended to relate to all records predating said execution.

I acknowledge that: (1) I have the right to revoke the authorization at any time, and (2) I understand that once the information is disclosed hereunder, it may no longer be protected by federal privacy law. I understand that I may revoke this authorization only in writing sent to you by certified mail. The revocation will be effective only upon receipt, except to the extent you have acted in reliance on the authorization.

I understand that your treatment is not conditioned on my signing this authorization, although exceptions will be made for treatment the purpose of which is creating protected health information to a third party.

I understand that refusal to sign this authorization will have no effect on my enrollment, eligibility for benefits, or the amount a third party payors pays for the health services I receive.

I understand that the person or entity that receives this information may not be covered by the federal privacy regulations, in which case the information above may be redisclosed and no longer protected by these regulations. I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for the use and/or disclosure.

I have a right to receive a copy of this authorization. I may inspect or obtain a copy of the protected health information that I am being asked to use or disclose.

By signing my name below I am authorizing you to release documentation which may include highly confidential health information relative to my medical status in the following categories: HIV/AIDS, Mental Health, Sexually Transmitted Disease, Drug and Alcohol Use.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Witness **Date**

PRE-FIGHT MEDICAL QUESTIONNAIRE

Contestant's Name _____ **Age** _____

1. Yes ( ) No ( ) Have you had an MRI/MRA or CT scan of the head for any reason other than state licensing? If yes, explain _____

2. Yes ( ) No ( ) Have you ever had any eye problems, surgery (*Lasik, PRK*), or special examinations? If yes, explain _____

3. Yes ( ) No ( ) Have you had any eye problems or eye issues since your annual exam was done? If yes, explain _____

4. Yes ( ) No ( ) Do you have any serious medical illnesses, diseases, conditions, or allergies of any kind? If yes, explain _____

5. Yes ( ) No ( ) Have you had any broken bones in last 6 months? If yes, explain _____

6. Yes ( ) No ( ) Have you had any injury to your shoulders, elbows, or hands that needed evaluation or examination? If yes, explain _____

7. Yes ( ) No ( ) Have you had any injury to your knees, ankles, or feet that needed evaluation or examination? If yes, explain _____

8. Yes ( ) No ( ) Have you had any lacerations or cuts that required sutures or glue in the last 3 months? If yes, explain _____

9. Yes ( ) No ( ) Have you had any surgeries or been hospitalized within the last year? If yes, explain _____

10. Yes ( ) No ( ) Have you taken or received *any* medication, drug, cream, ointment, inhalant, intravenous infusions, or injections, whether prescription or over-the-counter, from anyone or anyplace, in the last month? If yes, explain _____

11. Yes ( ) No ( ) Have you taken or received *any* nutritional supplement or vitamin in the last month? If yes, explain _____

12. Yes ( ) No ( ) Have you taken or received *any* medication, drug, supplement, cream, inhalant, or pill to help you lose weight or cut water for this bout? If yes, explain

_____

13. Yes ( ) No ( ) Do you understand that if you are hospitalized and/or receive an intravenous (IV) infusion after the weigh-in you are required to immediately notify the Nevada State Athletic Commission?

14. Yes ( ) No ( ) Have you suffered a KO, TKO, or any kind of loss of consciousness in the last 6 months during a bout, sparring, or any other activity? If yes, explain _____

15. What was your weight 2 weeks ago? _____ What was your weight 1 week ago? _____

16. When was your last bout, and what was the result of that bout? _____

I hereby swear, under penalty of perjury, that the above information is true and correct to the best of my knowledge. I certify that I have read or had read to me the contents of this agreement in a language or manner that I understand. I sign this questionnaire/agreement under no duress and with full understanding of the terms contained herein.

I further agree to submit to any and all post-match medical treatment, as recommended by the State's medical personnel, including but not limited to transport to the hospital for evaluation and testing. I acknowledge that failure to comply with recommended medical treatment constitutes a refusal to comply with a valid order of a representative of the Commission. As such, I understand that failure to submit to recommended medical treatment provides grounds for disciplinary action, pursuant

to NAC 467.885(4), that may lead to a suspension or revocation of my license. Finally, if I choose to refuse recommended medical treatment, I hereby release for myself, as well as my heirs, the State and each of its employees, medical providers, and independent contractors, in their individual and representative capacities, from any and all liability that may result from my refusal of recommended medical treatment and/or evaluation.

_____ _____

Contestant's signature Second's signature & printed name (Must be a licensee)

NSAC Physician conducting this Evaluation: _____ on _____, 201__