Check One (if a double header) - Day 1 _______ Day 2 _______ Both Days _______

Bike #	Status

I.D. #
Exp. Date
Transponder #
AMA #

WERA SPRINT MASTER ENTRY FORM

WERA Motorcycle Roadracing

Track ________________________ Event Date ____________ Comp# ________

Name _________________________ Address __________________________________

City ______________________ State _______ Zip __________ Phone # (   ) ______-_________

Sponsor(s) ____

____

Emergency Contact Name ___________________________________ E.C. Phone (   )_____________________

Class	Brand/cc	Fees	Class	Brand/cc	Fees
A Superstock	____________	________	500 GP	____________	________
B Superstock	____________	________	Vintage 3	____________	________
C Superstock	____________	________	Vintage 4	____________	________
D Superstock	____________	________	Formula 2-Stroke	____________	________
E Superstock	____________	________	Vintage 5	____________	________
F Superstock	____________	________	Vintage 6 Lightweight	____________	________
Lightweight Twins SS	____________	________	Vintage 6 Heavyweight	____________	________
Senior Superbike HW	____________	________	Vintage 7 Mediumweight	____________	________
Senior Superbike MW	____________	________	Vintage 7 Heavyweight	____________	________
Formula 1	____________	________	Vintage 8 Mediumweight	____________	________
Formula 2	____________	________	Vintage 8 Heavyweight	____________	________
Clubman	____________	________	Minis - 80cc 50cc Grom	____________	________
Heavyweight Twins SB	____________	________	Minis - 80cc 50cc Grom	____________	________
Lightweight Twins SB	____________	________	Minis - 80cc 50cc Grom	____________	________
A Superbike	____________	________	Other/Practice	____________	________
B Superbike	____________	________	Other/Practice	____________	________
C Superbike	____________	________	Other/Practice	____________	________
D Superbike	____________	________			

Total Race Fees	________	Credit Card Number:______________________________	Cash	________
Transponder	________	Cardholder Name:________________________________	Check	________
Membership	________	Signature:______________________________________	Charge	________
Riders School	________	Exp Date:____________ CVV Code:____________	Credit(s)	________
Total Fees	________		**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 ______________________________