



WAR-P Public Affairs Form

For use by Wounded Warrior Regiment Public Affairs Office

Information supplied on the following pages will be used for biographical information on the Wounded Warrior Regiment website, public affairs products and to give accurate biographical information to your hometown media, local, regional and national media outlets. ACCURACY IS ESSENTIAL! Please take the time to fill this sheet out as thoroughly as possible. Print legibly, please!

NAME _____ RANK _____ STATUS (circle one): **Active Reserve Veteran**

TODAY I AM PARTICIPATING IN (circle one):

Camp: Sport _____ **Marine Corps Trials:** List team _____ **Warrior Games**

UNIT YOU BELONG TO _____ WWR BN OR DET (i.e. Balboa, Bn West) _____

BIRTH DATE (Month, Day, Year) _____ AGE _____

HOMETOWN(with state) _____

Please note, this is the hometown you want listed, not necessarily where your parents live now.

HIGH SCHOOL (name, city, state) _____

HIGH SCHOOL SPORTS EXPERIENCE? _____

COLLEGE (if applicable) _____

COLLEGE SPORTS EXPERIENCE? _____

ATHLETIC AWARDS EARNED? _____ OTHER ATHLETIC ACTIVITIES? _____

INJURY or ILLNESS (optional) _____

PHONE (best way to reach you) _____ EMAIL (so we can send you photos) _____

Why did you choose to participate today?

What do you hope to accomplish while you are here? *(List anything, such as enjoying camaraderie, getting out of your routine, trying something new or training for competition)*

When you were younger, who inspired you and why? Who inspires you now and why?

Briefly describe your training regimen leading up to this event and anyone who helped you train for this event.

What part of your training and preparation has been the most challenging?

Are you a fan of a particular team and/or athlete? Why?



WAR-P Public Affairs Form (cont.)

HIPAA PRIVACY

AUTHORIZATION FOR RELEASE OF INFORMATION

YOUR INFORMATION		
LAST NAME: [REDACTED]	FIRST NAME AND MIDDLE INITIAL: [REDACTED]	PHONE NUMBER: [REDACTED]
ADDRESS [REDACTED]	CITY/STATE: [REDACTED]	ZIP CODE: [REDACTED]

Person/Organization Providing the Information <i>[DoD 6025.18R C5.3.1.2]</i>	Person/Organization to Receive the Information <i>[DoD 6025.18R C5.3.1.3]</i>
Athlete participating in Wounded Warrior Regiment activities	Wounded Warrior Regiment Public Affairs Office and media outlets covering WRR events. Contact info will not be released.

Description of the Information to be Released (Provide a detailed description of the specific information to be released) <i>[DoD 6025.18-R, C5.3.1.1]</i> Information provided on the preceding pages (Not contact info) and information the athlete discloses during interviews.

Description of Each Purpose for the Use or Release of the Information (Provide a detailed description of the activity for which the information will be used) <i>[DoD 6025.18-R, C5.3.1.4]</i> The information will be used to publicize WWR events and the athletes who participate.
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This authorization for release of the above information to the above named persons/organizations will expire on: N/A. *[DoD 6025.18R, C5.3.1.5]*

I understand:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I have the right to revoke this authorization. *[DoD 6025.18-R C5.3.2.1]*
- I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization.
- **I understand that I cannot revoke information once it has been given to the media.** *(Covered entities must select one of the following: 1) this authorization because the covered entity has taken action in reliance on the authorization, or 2) the authorization because it was obtained as a condition of obtaining insurance coverage) [DoD 6025.18-R C5.2.5]*
- I understand that I am signing this authorization voluntarily and that treatment, payment or eligibility for my benefits will not be affected if I do not sign this authorization. *[DoD 6025.18-R C5.3.2.2.1]*
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. *[DoD 6025.18-R C5.3.2.3]*
- I understand I have the right to receive a copy of this authorization. *[DoD 6025.18-R C5.3.4]*
- I understand DoD covered entities may use and disclose protected health information (PHI) of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission. *[DoD 6025.18-R C7.11.1.1]*

WAR Program Athlete Authorization: By filling out and signing this form, you give the Wounded Warrior Regiment public affairs office permission to publicize your individual accomplishments in athletic competition and other life successes at any time. This includes the photos and information in news stories and releases from camps, the Marine Corps Trials and the Warrior Games.

Signature: [REDACTED]	Signature of Parent (if patient is under legal age of consent): [REDACTED]	Date: [REDACTED]
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[DoD 6025.18-R, C5.3.1.6].

When using or disclosing protected health information (PHI) in any form or when requesting PHI from another covered entity, a covered entity shall make reasonable efforts to limit the use, disclosure, or request of PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. *[DoD 6025.18-R C8.2.1]*