



2012 USTA PROFESSIONAL CIRCUIT CONSENT AND WAIVER FORM

I, ,

in consideration of acceptance of my entry to the United States Tennis Association Incorporated (“USTA”) 2012 Professional Circuit (“Professional Circuit”), understand and agree to the following:

1. The USTA shall have the right in perpetuity, for the purpose of the promotion and/or the advertising of tennis or any Professional Circuit event in which I play, to use my name, photograph, likeness, biography, voice or other identification, in print, film, radio, television, Internet and/or any other media now known or hereafter devised and in all other publicity and promotional materials and media, including the right to use and/or sublicense such right to use the same on event posters, photos, programs, merchandise and other materials. The USTA shall have the right in perpetuity, without additional compensation, to make, use, show and/or license for any and all purposes, in a commercial and/or non-commercial manner, still pictures, motion pictures, live or delayed on television and/or any other media now known or hereafter devised, including the Internet, of me taken during a Professional Circuit event. However, notwithstanding anything set forth herein, the use of my identification (e.g. name, photograph, likeness, biography, voice, etc.) shall not be identified as or represented to be an endorsement by me of any product, service or company.
2. As a condition of my participation on the Professional Circuit, I, for myself and my executors, administrators, heirs, personal representatives, successors and assigns, waive any and all claims of any kind, nature and description, including past, present or future claims and injuries, if any, sustained in traveling to or from or participating in any Professional Circuit event and/or any of its related activities and/or while in the location of any Professional Circuit event, as against the USTA, ITF, ATP, WTA, promoters, sponsors, television licensees, vendors, venues, local organizers and others connected with such Professional Circuit events, including their employees, officers, directors, volunteers, and representatives.
3. I am aware and accept that I am strictly prohibited, directly or indirectly through others, from: (a) wagering anything of value in connection with the Professional Circuit; and (b) offering or receiving anything of value to or from any person with the intent to influence any player’s efforts in the Professional Circuit.
4. The USTA and I shall at all times be independent contractors and my agreement to participate on the Professional Circuit shall not in any way create or form an employer-employee relationship or a partnership or joint venture between us.
5. As a condition of my participation on the Professional Circuit, I hereby authorize medical personnel (including trainers and tournament doctors) to provide medical or diagnostic services to the player in the event that the player becomes ill or sustains an injury in connection with player's participation in the Professional Circuit.
6. The Men’s Futures Satellite events and all Women’s events on the Professional Circuit are governed by and conducted pursuant to the regulations promulgated and amended from time to time by the ITF (“ITF Regulations”). The ITF Regulations include a Code of Conduct and an extensive provision relating to drug testing and other medical examinations. If applicable, I agree to be bound by the ITF Regulations, a current copy of which will be made available to me upon request. The Men’s Challenger events on the Professional Circuit are governed by and conducted pursuant to the regulations promulgated and amended from time to time by the ATP (“ATP Regulations”) which also include a Code of Conduct and an extensive provision relating to drug testing and other medical examinations. If applicable, I agree to be bound by the ATP Regulations, a current copy of which will be made available to me upon request.

READ AND AGREED:

Player Signature

Date of Birth

Date of Signature

Signature of Parent(s)/Guardian(s) (if under 18)



Authorization for Release of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that you, or your legal representative, consent in writing to the disclosure of your protected health information, including your medical records. By signing this form, your protected health information can be given to the individuals and/or entities listed on this form, for the reasons listed in this form.

Please read all statements on this form carefully, as it describes your rights regarding the use or disclosure of your protected health information and medical records that are subject to this authorization.

I, the undersigned, authorize any USTA Pro Circuit Trainer and/or USTA Pro Circuit Tournament Doctor that provides medical treatment to me during any USTA Pro Circuit event (the "Covered Entities") to disclose to designated USTA representatives, any USTA Pro Circuit Trainer, and/or any USTA Pro Circuit Tournament Doctor the following protected health information: medical records and treatment logs that contain information with respect to any treatment and/or medical services provided to me at a USTA Pro Circuit event.

The protected health information and medical records covered by this authorization may be used for the following purposes: for USTA, USTA Pro Circuit Trainers and/or USTA Pro Circuit Tournament Doctors at each of the USTA Pro Circuit events during this calendar year (January 1, 2012 to December 31, 2012) to provide continuity of medical treatment and player care. This authorization will remain effective until December 31, 2012.

I understand that I have the right to revoke this authorization, in writing, at any time (except to the extent that the Covered Entities have acted in reliance upon this authorization) by sending notification by secured carrier to: *Chief Legal Officer, USTA, 70 West Red Oak Lane, White Plains, NY 10604*. I understand that a revocation will prevent the Covered Entities from further use or disclosure of my protected health information, but it will not retract the uses or disclosures that have already been made pursuant to the authorization.

I understand that the protected health information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization.

I understand that the Covered Entities cannot condition my treatment based upon whether I sign this authorization.

I understand that I have the right to inspect and copy the protected health information and medical records covered by this authorization.

I understand that I have the right to receive a copy of this authorization.

By signing below I acknowledge that I have read and understand my rights relating to this authorization for the use or disclosure of my protected health information and medical records.

Print Name

Signature

Date

Signature of Parent(s)/Guardian(s) (if under 18)