HIPAA AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION
(DRIVERS / COMPETITORS)

Name:_____ Telephone:(_____)_____ Date of Birth:_____
Address:_____

This Authorization Form describes different uses and disclosures of health information, including as protected under applicable state and provincial law and also "protected health information" as defined by the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations promulgated thereunder. Unless otherwise revoked by me in writing, this Authorization expires eighteen (18) months after the date of signing this Authorization ("Expiration Date").

I hereby authorize the following uses and disclosures of my Health Information, as defined below, and as permitted or required by law:

☐ ***(initial)*** **A.** General. I specifically authorize and direct any physician, healthcare provider, hospital or other healthcare facility who provided or is providing assessment, diagnosis, care, treatment or services to me prior to execution of this Authorization and/or any time after execution of this Authorization up to the Expiration Date, including their agents, employees and medical staff (collectively "Health Care Provider") to release my "Health Information" (as defined below) to (1) the NASCAR Medical Liaison Department and/or their designated agents and employees (collectively "Medical Liaison Department"); (2) NASCAR Event Management, LLC, their affiliates, agents, employees and consultants (collectively "NEM"); and/or (3) the racing series Substance Abuse Policy's designated Medical Review Officer or its designated agent (collectively "Medical Review Officer") as requested by them for the purposes of safety, quality assurance/quality improvement, my ability or eligibility to compete, and/or my assessment, treatment or care, whether related to a medical, psychological, psychiatric, or substance abuse condition. *"Health Information" is defined as: the full and complete medical record; hospital chart; medical history; notes; reports; data; test results; radiology reports, images and films (such as CT, MRI, and x-ray); documents related to examination or treatment for any physical or mental health condition, sickness or injury; assessments; diagnoses; prognoses; medications and prescriptions; insurance records; physician notes of patient interviews; privileged or private communications; and any and all other health information or records regarding my health or treatment, including correspondence, patient notes, and phone messages. I understand Health Information includes records disclosed to the Health Care Providers by other healthcare providers and facilities who previously provided treatment to me, and that it may include information and records protected under applicable state and provincial law (such as certain conditions) and federal law (such as alcohol or drug abuse).*

☐ ***(initial)*** **B.** Contagious, Infectious, or Communicable Disease. I specifically authorize and direct any Health Care Provider to release to the Medical Liaison Department, NEM, and/or to the Medical Review Officer any Health Information about me regarding assessment, diagnosis, care or treatment of a contagious, infectious or communicable disease (including, but not limited to, HIV/AIDS information, COVID-19 information, tuberculosis, measles, negative/positive diagnosis, testing, test results, status and treatment), if applicable.

☐ ***(initial)*** **C**. Mental Health Information. I specifically authorize and direct any Health Care Provider to release to the Medical Liaison Department, NEM, and/or to the Medical Review Officer any Health Information about me regarding assessment, diagnosis, care or treatment of a mental health condition, illness, or disease, if applicable, for the purposes of safety, quality assurance/quality improvement, my ability or eligibility to compete, and/or for my assessment, treatment or care. This Authorization does not include the release of "psychotherapy notes" (as that term is defined by HIPAA) recorded by a healthcare provider who is a mental health professional regarding a counseling session, but only if such notes are held separately from my medical record. This Authorization does include, for example, all information held in my medical record, other professional notes, medication prescriptions and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

☐ ***(initial)*** **D.** Alcohol/Drug Abuse. I specifically authorize and direct any Health Care Provider to release to the Medical Liaison Department and/or to the Medical Review Officer any Health Information about me regarding assessment, diagnosis, care, treatment or referral regarding alcohol and/or drug abuse, if applicable, for the purposes of safety, quality assurance/quality improvement, my ability or eligibility to compete, and/or for my assessment, treatment or care.

☐ ***(initial)*** **E.** Discussion Permitted. I specifically authorize and direct any Health Care Provider to discuss, clarify or explain my Health Information with the Medical Liaison Department and/or the Medical Review Officer, upon their request, for the purposes of safety, quality assurance/quality improvement, my ability or eligibility to compete, and/or for my assessment, treatment or care.

☐ ***(initial)*** **F.** Disclosure by Medical Liaison for Certain Purposes. I authorize the Medical Liaison Department to use and disclose my Health Information in their possession, including but not limited to my Driver History & Physical Forms, Track Incident Medical Reports, and Infield Care Center Reports, to the following: (1) physicians, health care providers, hospitals, infield care centers, state and local health departments, and other health care facilities or medical providers for purposes of my assessment, care and treatment; and/or (2) the Medical Review Officer, NEM, and outside experts, engineers, physicians or consultants retained by any of them, for purposes of safety, quality assurance/improvement, my ability or eligibility to compete, to assist in reviewing accidents and health care services, and making assessments and recommendations related to quality or safety. I understand the Medical Liaison Department coordinators and consulting physicians are not direct treatment providers; they are present at the racetracks to facilitate the sharing of information.

☐ ***(initial)*** **G.** Medical Review Officer Request. I acknowledge that, under the rules of the racing series Substance Abuse Policy, the Medical Review Officer serves as an independent and impartial physician who investigates whether a laboratory non-negative test result was due to a legitimate medical explanation. I understand that under these rules the Medical Review Officer may request medical information and records as part of inquiring into whether there is a legitimate medical explanation for a result. I specifically request and permit Health Care Providers and the Medical Liaison Department to disclose, discuss and explain my Health Information as necessary to respond to such a request from the Medical Review Officer.

I understand that I have the right to revoke this Authorization in writing at any time by notifying, as applicable, the disclosing Healthcare Provider, Medical Liaison Department, and/or the Medical Review Officer. I understand that the revocation is only effective after it is received. I understand that any use or disclosure made prior to the revocation in reliance on this Authorization will not be affected by a subsequently received revocation. This signed Authorization supersedes and replaces prior HIPAA authorizations, if any, that I have signed for NEM.

I understand that once Health Information is disclosed pursuant to this Authorization, it may be re-disclosed by the recipient, and federal or applicable state and provincial law might not protect it. I understand a health care provider, hospital or health facility may not condition my treatment on whether this Authorization is signed. I understand that the racing series rules and policies will govern whether I may participate in any sanctioned event if I choose to revoke this Authorization.

I have read this Authorization, I understand what it says, and any questions of mine have been answered to my satisfaction. I understand that I am entitled to receive a copy of this Authorization, and I allow a photocopy to be deemed valid as a signed original.

Signature: _____ Date:_____