2020
INDYCAR
Participant Authorization for Use and Disclosure of Protected Health Information

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I understand that in the event I need medical treatment while involved in and/or participating in activities as part of INDYCAR, LLC ("INDYCAR"), the health care providers giving that treatment will know confidential and protected health information about me. I also understand that there may be inquiries from the media or the public about my medical condition, and that it is in my best interests that any information that is publicly disclosed about my medical condition be accurate.

Therefore, I hereby authorize INDYCAR's Medical Director and/or his representatives (including, but not limited to, the physicians employed by and/or associated with Indiana University Health, Inc. in Indianapolis, Indiana) to disclose protected health information about me to INDYCAR officials, ACCUS-FIA officials, members of the INDYCAR public relations staff, and media so that press releases and other public announcements can be made about my medical condition under appropriate circumstances. I also authorize the INDYCAR Medical Director and/or his and other INDYCAR representatives to disclose medical and testing information, including protected health information, to third parties for purposes of safety or medical research or product development and where deemed necessary by INDYCAR consistent with INDYCAR's standard practice of maintaining confidentiality subject to certain exceptions and with notice to Members.

Furthermore, I hereby authorize and give permission to any and all health care facilities, physicians and other health care professionals to disclose and release any and all information, including protected health information, about me regarding my medical condition and/or injuries to INDYCAR's Medical Director and/or his representatives.

Description of information: The protected health information that I authorize to be disclosed and received includes the nature and extent of any injuries or illness I may incur while involved in INDYCAR activities, my general medical condition, the nature and extent of medical treatment, including testing, I have received and may receive, and my prognosis.

Purpose of disclosure: The purpose of this disclosure is to help ensure that any information about my medical condition that is disclosed is accurate, to assist INDYCAR with its duties and obligations, to minimize the possible harmful effects of speculation and rumors, and to assist health care providers in rendering care.

Expiration of authorization: This authorization expires one year from the date signed.

My rights: I understand that this authorization is voluntary and that I may revoke it at any time prior to its expiration by notifying the Vice President, Communications of INDYCAR, in writing. I also understand that the revocation will not have any effect on any actions taken in reliance on this authorization or any use or disclosure of protected health information about me that occurred before the Vice President, Communications received the revocation. I may inspect and copy the protected health information described on this form, to the extent it is written, if I ask for it. I am not required to sign this authorization to be able to receive medical treatment. I understand that the protected health information that is used or disclosed in accordance with this authorization may be re-disclosed by people who receive it, and may no longer be protected by federal or state privacy laws. I also understand that I am entitled to have a copy of this authorization if I request it.

DATE: _____ 

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PRINTED NAME: _____