2024
INDYCAR
Minor Participant Authorization for Use and Disclosure of Protected Health Information[1]

Printed legal name of minor:_____(minor) **Age of minor:**_____

I am the legal parent and/or guardian of minor, and for myself and on behalf of minor I agree to the terms and conditions of this INDYCAR Minor Participant Authorization for Use and Disclosure of Protected Health Information. I and minor understand that in the event minor needs medical treatment while involved in and/or participating in racing (including without limitation practice, qualifications, and races), testing, exhibitions, promotional and/or entertainment or other activities associated with, sanctioned by and/or organized in cooperation with INDYCAR, LLC ("INDYCAR") or occurring at the site of, contemporaneously with or reasonably connected thereto, the health care providers giving that treatment will know confidential and protected health information about minor. I and minor also understand that there may be inquiries from the media or the public about minor's medical condition, and that it is in minor's best interests that any information that is publicly disclosed about minor's medical condition be accurate.

Therefore, I and minor hereby authorize INDYCAR's Medical Director and/or his or her representatives (including, but not limited to, the physicians employed by and/or associated with Indiana University Health, Inc. and/or Indiana University Health Physicians in Indianapolis, Indiana) and other medical professionals providing treatment and/or care to minor to disclose protected health information about minor 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 minor's medical condition. I and minor also authorize the INDYCAR Medical Director and/or his or her and other medical and 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 and minor 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 minor regarding minor's medical condition and/or injuries to INDYCAR's Medical Director and/or his or her representatives.

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

Purpose of disclosure: The purpose of this disclosure is to help ensure that any information about minor's 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 and minor understand that this authorization is voluntary and that it may be revoked at any time prior to its expiration by notifying the Vice President, Communications of INDYCAR, in writing. I and minor 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 minor 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 and if such disclosure is permitted by law. I am not required to sign this authorization for minor to be able to receive medical treatment. I and minor 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.

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[1] Capitalized terms used but not otherwise defined herein shall have the meaning as defined in the applicable series Rule Book.

Printed legal name of parent or guardian _____

Signature of parent or guardian _____READ! THIS IS A LEGALLY BINDING DOCUMENT_____

Date _____

Printed name of witness _____

Signature of witness _READ! THIS IS A LEGALLY BINDING DOCUMENT_____

Printed legal name of parent or guardian _____

Signature of parent or guardian _____READ! THIS IS A LEGALLY BINDING DOCUMENT_____

Date _____

Printed name of witness _____

Signature of witness _READ! THIS IS A LEGALLY BINDING DOCUMENT_____

Minor Signature showing acknowledgement and acceptance

_____READ! THIS IS A LEGALLY BINDING DOCUMENT_____

Date _____

Printed name of witness _____

Signature of witness _READ! THIS IS A LEGALLY BINDING DOCUMENT_____

STATE OF _____)
) SS: _____
COUNTY OF _____)

Before me, a Notary Public in and for said County and State, personally appeared _____, parent or legal guardian of _____, and acknowledged the execution of the foregoing 2024 INDYCAR Minor Participant Authorization for Use and Disclosure of Protected Health Information (HIPAA).

WITNESS MY HAND AND NOTARIAL SEAL THIS ___ DAY OF _____, 202_.

Notary Public (signed/printed): _____

My Commission Expires: _____

Resident of _____ County, _____ State, _____ Country

STATE OF _____)
) SS: _____
COUNTY OF _____)

Before me, a Notary Public in and for said County and State, personally appeared _____, parent or legal guardian of _____, and acknowledged the execution of the foregoing 2024 INDYCAR Minor Participant Authorization for Use and Disclosure of Protected Health Information (HIPAA).

WITNESS MY HAND AND NOTARIAL SEAL THIS ___ DAY OF _____, 202_.

Notary Public (signed/printed): _____

My Commission Expires: _____

Resident of _____ County, _____ State, _____ Country