COVID-19 HIPAA AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

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 one (1) year from the date signed below ("Expiration Date"). I hereby authorize the following uses and disclosures of my Health Information, as defined below, and as permitted or required by law: The purpose of this Authorization is to review and process my request to attend or participate in NASCAR-sanctioned events or activities.

☐ ***(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 agents, employees, and designees onsite or remotely available at a NASCAR event or activity (collectively "Medical Liaison Department"); and/or (2) NASCAR Event Management, LLC, their affiliates, agents, employees and consultants (collectively "NEM") about me regarding assessment, diagnosis, care or treatment of COVID-19 (including, but not limited to negative/positive diagnosis, testing, test results, status and treatment), if applicable*. "Health Information" is defined as: the full and complete medical record; notes; reports; data; test results; documents related to examination or treatment for COVID-19; assessments; diagnoses; prognoses; medications and prescriptions; physician notes of patient interviews; privileged or private communications; and any and all other health information or records regarding my health or treatment, including questionnaires, correspondence, patient notes, and phone messages but excluding Psychotherapy Notes (as defined by HIPAA). I understand Health Information may include records disclosed to the Health Care Providers by other healthcare providers and facilities who previously provided treatment to me, might include information regarding conditions other than COVID-19, and may also include information and records protected under applicable state and provincial law and federal law, such as HIV, AIDS, mental health, substance abuse and other communicable diseases.*

☐ ***(initial)*** **B.** Discussion Permitted. I specifically authorize and direct any Health Care Provider to discuss, clarify or explain my Health Information with the Medical Liaison Department upon their request, for the purposes of safety, quality assurance/quality improvement, compliance, public health, and/or related to my COVID-19 screening questionnaire, assessment, treatment or care.

☐ ***(initial)*** **C.** Disclosure by Medical Liaison for Certain Purposes. I authorize the Medical Liaison Department to use and disclose my Health Information in their possession 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 safety, compliance, public health, or my assessment, care and treatment; and/or (2) NEM, and outside experts, physicians or consultants retained or designated by any of them, for purposes of safety, compliance, public health, quality assurance/improvement and making assessments and recommendations related to quality, safety or public health; and/or (3) as otherwise permitted or required by law. I understand the Medical Liaison Department coordinators and consulting physicians are not direct treatment providers and do not create a patient relationship with me; they are present at the racetracks to facilitate the sharing of information. This HIPAA authorization is being obtained to the extent HIPAA applies to the Medical Liaison Department or others. This COVID-19 screening and assessment is conducted for work safety and/or public health purposes; it is not on behalf of any health plan and is not a health plan benefit.

I understand that I have the right to revoke this Authorization in writing at any time by notifying, as applicable, the disclosing Health Care Provider and/or Medical Liaison Department. Revocation notices for the Medical Liaison Department should be sent to: One Daytona Boulevard, Dayton Beach, FL 32114. 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.

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, health facility or health plan may not condition my treatment, payment, enrollment or eligibility for benefits on whether this Authorization is signed. I understand that NASCAR and NEM rules and policies will govern whether I may attend or participate in any NASCAR-sanctioned event or activity if I choose not to sign this Authorization or revoke it.

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. I certify that I am eighteen (18) years or older, and I voluntarily agree to the terms of this Authorization.

Signature: ____ Date:____________________________