2012 INDYCAR
PARTICIPANT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECED HEALTH INFORMATION

I understand that in the event I need medical treatment while participating in activities as part of the Indy Racing League, LLC d/b/a INDYCAR ("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, or their representative (including, but not limited to, the physicians employed by and/or associated with Indiana Clinic in Indianapolis, IN) to disclose, with discretion, 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 representatives to disclose information, including protected health information, to third parties for purposes of safety or medical research or product development.

Furthermore, I hereby authorize and give permission to any and all health care facilities, physicians and other medical 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 its 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 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 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 Amy Konrath of the INDYCAR public relations staff, 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 Ms. Konrath 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: _____ SIGNATURE: _____

PRINTED NAME: _____