



NASCAR Medical Liaison Department

Office: 386-310-6400 | Fax: 386-310-6405 | MLC@nascar.com

Dear Driver aged 18 and under,

Please find enclosed the 2026 Minor Driver History and Physical Examination, and HIPAA Authorization for the Use and Disclosure of Health Information forms. Medical information will only be used for safety, fitness-to-drive determination, and emergency medical care coordination. Incomplete or inaccurate forms may delay or prevent participation. Completion of this packet does not guarantee medical clearance. NASCAR reserves the right to request additional information or independent evaluation to ensure the safety of all participants.

Due to applicable laws in the various states and/or provinces in which you may compete, all drivers who are 18 and under at the time of his/her initial 2026 on-track participation must complete and sign applicable forms for MINOR competitors. Login to [NASCARMembers.com](https://www.nascarmembers.com) or contact the NASCAR Medical Liaison Department to obtain the appropriate forms. If you are 18 or under, please ensure the forms provided herein are labeled for Minor Drivers and are signed by your parent(s) or legal guardian. Additionally, this packet includes a [Consent for Treatment of a Minor](#) form that must be signed and witnessed by your parent(s) or legal guardian. If you have not received the correct forms based upon your age, please contact the Medical Liaison Department for the appropriate documents. Finally, should you reach 19 years of age during the season, **it is your responsibility to immediately update your health records with the Medical Liaison Department and re-sign the appropriate authorization forms for non-minor drivers.**

It is vitally important for the safety and wellbeing of all competitors that the medical information you provide is accurate. Thoroughly complete all sections of the History and Physical form and sign in the designated location. Your personal physician should complete and sign the Physical Exam form based upon their review of your medical information and the physical exam. **You should schedule your physical examination in a timely manner and ensure that a licensed physician (MD or DO) will be available to sign or co-sign your form. Signatures of APP's (Physician Assistants or Nurse Practitioners) without physician co-signature will not be accepted. Exams completed by telehealth, chiropractors, or NMD will not be accepted.** Your physical must be performed on or after December 1, 2025.

Review the HIPAA Authorization form, complete the top portion, initial all sections, sign with original signature, and date the bottom.

NASCAR National and ARCA Series drivers are required to submit a complete copy of their current ImPACT baseline completed within the past two years prior to arriving at the track. National Series drivers must also complete an annual baseline King-Devick Test at the Infield Care Center.

All forms must be received by the Medical Liaison Department with ample time for review and resolution of any concerns, and prior to any on-track participation. Upon receipt of your documents, one of the Medical Liaisons may contact you to review.

Retain a copy of all documents for your records and return all original forms to:

***NASCAR Medical Liaison Department
One Daytona Boulevard
Daytona Beach, FL 32114***

IMPORTANT:

Do not enclose your medical forms with any documents sent to other NASCAR departments or representatives.

If you need assistance while completing your forms, please feel free to contact any member of the Medical Liaison team. Once these requirements have been fulfilled, your information will be applied across all NASCAR racing series in which you may compete. Touring Series drivers who plan to compete in any of the National Series or ARCA will need to meet the additional requirements prior to any on-track activity. We thank you in advance for your cooperation.

Sincerely,

Medical Liaison Department

NASCAR MEDICAL FORM REQUIREMENTS FOR AGE AND SERIES

	National Series (NCS, NOAPS, NCTS) and ARCA	Touring Series (NWMT, Canada)
Age 19 and Over	<input type="checkbox"/> Medical History form with driver signature <input type="checkbox"/> Physical completed on or after December 1, 2025 and signed by physician (MD or DO) <input type="checkbox"/> HIPAA form, initial A-G, signed at bottom <input type="checkbox"/> Valid ImPACT baseline dated within the last two years <input type="checkbox"/> Baseline King-Devick Test completed at the Infield Care Center within the last year (recommended for ARCA)	<input type="checkbox"/> Medical History form with driver signature <input type="checkbox"/> Physical completed on or after December 1, 2025 and signed by physician (MD or DO) <input type="checkbox"/> HIPAA form, initial A-G, signed at bottom <input type="checkbox"/> Valid ImPACT baseline dated within the last two years (highly recommended)
Age 18 and Under	<input type="checkbox"/> MINOR Medical History form with driver and parental or legal guardian signatures <input type="checkbox"/> Physical completed on or after December 1, 2025 and signed by physician (MD or DO) <input type="checkbox"/> MINOR HIPAA form, initial A-G, with driver, parental or legal guardian and witness signatures <input type="checkbox"/> Consent for Treatment of a Minor form, signed by parent or legal guardian and witness <input type="checkbox"/> Valid ImPACT baseline dated within the last two years <input type="checkbox"/> Baseline King-Devick Test completed at the Infield Care Center within the last year (recommended for ARCA)	<input type="checkbox"/> MINOR Medical History form with driver and parental or legal guardian signatures <input type="checkbox"/> Physical completed on or after December 1, 2025 and signed by physician (MD or DO) <input type="checkbox"/> MINOR HIPAA form, initial A-G, with driver, parental or legal guardian and witness signatures <input type="checkbox"/> Consent for Treatment of a Minor form, signed by parent or legal guardian and witness <input type="checkbox"/> Valid ImPACT baseline dated within the last two years (highly recommended)

PHYSICAL EXAM REQUIREMENTS

If the requirements below are not met (as outlined on the physical exam page), the examination is considered incomplete and will not be accepted until corrected signatures are obtained. NASCAR is aware that certain states recognize that Advanced Practice Providers (APP) function without direct physician oversight; however, **an APP (NP or PA) signature is not adequate for the racing series physical exam.**

Medical Doctor	{	<ul style="list-style-type: none"> • Exam • Fully completed physical form including signature and license information
Doctor of Osteopathy	{	<ul style="list-style-type: none"> • Exam • Fully completed physical form including signature and license information
Physician Assistant (APP)	{	<ul style="list-style-type: none"> • Exam • MD or DO co-signature • Fully completed license information for PA and physician
Nurse Practitioner (APP)	{	<ul style="list-style-type: none"> • Exam • MD or DO co-signature • Fully completed license information for NP and physician
Doctor of Chiropractic	{	<ul style="list-style-type: none"> • Not recognized by NASCAR

2026 Minor Driver (aged 18 and under) History and Physical

This form is intended for MINOR drivers **aged 18 and under**.

NOTE: Drivers aged 19 and above must complete ADULT Driver History and Physical.

Submit Original Documents DIRECTLY and ONLY to the Medical Liaison Department

Scan: MLC@nascar.com
 Fax: 386.310.6405

Mail: NASCAR Medical Liaison Department
 One Daytona Boulevard
 Daytona Beach, FL 32114

Pages 1-6 to be completed by Driver and reviewed with Examining Physician. Page 7 to be completed by Examining Physician.

Submission of this form with documented Physician's exam is required prior to any sanctioned on-track activity.

PLEASE PRINT CLEARLY

DRIVER DEMOGRAPHICS				
Legal Last Name	Legal First Name		Racing Name	
Date of Birth (Month / Day / Year)	Age	Gender	Marital Status	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	
Home Address	City	State / Prov	Zip / Country	
Mailing Address	City	State / Prov	Zip / Country	
Cell Phone	Alternate Phone	Email		

SERIES – These medical forms are applicable for and transfer to the following highlighted series:					
<input type="checkbox"/> NCS	<input type="checkbox"/> NOAPS	<input type="checkbox"/> NCTS	<input type="checkbox"/> ARCA	<input type="checkbox"/> NWMT	<input type="checkbox"/> NASCAR Canada Series
<input type="checkbox"/> Other series racing in 2026:					

CONTACTS			
Emergency Contacts (list two with at least one being a parent or legal guardian)			
Name	Relationship	Cell Phone	Alternate Phone
Name	Relationship	Cell Phone	Alternate Phone
Manager and PR Contacts			
Manager Name	Cell Phone	Email	
PR Contact Name	Cell Phone	Email	
<input type="checkbox"/> No current primary care physician		Personal Primary Care Physician	
Name	Specialty	Phone	
Address	City	State / Prov	Zip / Country

HISTORY

Have you **EVER** experienced any of the following? Respond to EACH line item, place check mark next to the appropriate diagnosis or symptom if applicable. Include year of discovery and explain any YES response in the space alongside.

General	YES	NO	Year and Explanation for Yes Responses
Anesthesia complications			
Cancer			
Seasonal allergies			
Burns			
Skin problem			
Psoriasis			
Eczema			
Eyes, Ears, Nose, Throat	YES	NO	Year and Explanation for Yes Responses
Difficulty swallowing			
Nose bleeds			
Hearing deficit or hearing loss			<input type="checkbox"/> Right <input type="checkbox"/> Left
Hearing aid			<input type="checkbox"/> Right <input type="checkbox"/> Left
Vision deficit or loss			<input type="checkbox"/> Right <input type="checkbox"/> Left
Color deficiency			
Contact lenses			
Contact lenses while driving race vehicle			
Corrective glasses			
Corrective glasses while driving race vehicle			
Corrective sunglasses			
Corrective sunglasses while driving race vehicle			
Reading glasses			Right eye strength: + _____ diopter Left eye strength: + _____ diopter
Corrective eye surgery (i.e. Lasik, PRK)			<input type="checkbox"/> Right <input type="checkbox"/> Left
Dentures			
Partial dental prosthesis			
Endocrine	YES	NO	Year and Explanation for Yes Responses
Diabetes			<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2
Hypoglycemia or low blood sugar			
Pre-diabetes			
Wear Continuous Glucose Monitor?			
Thyroid disorder			<input type="checkbox"/> Hyper <input type="checkbox"/> Hypo
Cardiovascular	YES	NO	Year and Explanation for Yes Responses
High blood pressure			
High cholesterol			
Peripheral vascular disease or circulatory problem			
Bleeding or clotting disorders			
Deep vein thrombosis (DVT or blood clot in legs)			
Palpitations			
Chest pain			
Angina			
Heart attack			

Coronary artery disease (CAD)			
Irregular heartbeat			
Valve disease			
Valve replacement			
Automatic implantable cardioverter defibrillator (AICD)			
Implanted pacemaker			
Pulmonary	YES	NO	Year and Explanation for Yes Responses
Asthma (reactive airway disease)			
Emphysema			
Chronic bronchitis			
COPD			
Pulmonary embolism (blood clot in lungs)			
Pulmonary hypertension			
Sleep apnea			
Gastrointestinal	YES	NO	Year and Explanation for Yes Responses
Heartburn or acid reflux			
Stomach ulcer			
Hernia			
Liver disease			
Hepatitis			
Cirrhosis			
Bowel problem			
Crohn's disease			
Diverticulitis			
Ostomy			
Cholecystectomy (gall bladder removal)			
Splenectomy (spleen removal)			
Genitourinary	YES	NO	Year and Explanation for Yes Responses
Bladder dysfunction			
Urinary difficulty			
Kidney dysfunction			
Kidney stones			
Enlarged prostate			
Orthopedic	YES	NO	Year and Explanation for Yes Responses
Arthritis			
Back problem			
Fractures (broken bones) – list site(s)			Site: Site: Site: Site:
Implanted metal plates, pins, or screws – list site(s)			Site: Site:
Joint problem			
Muscle problem			
Neck problem			
Spine problem			
Amputation			
Prosthesis			

Neurological	YES	NO	Year and Explanation for Yes Responses
ADD / ADHD			
Difficulty concentrating			
Dyslexia			
Autism spectrum disorder			
Tourette syndrome			
Motion sickness			
Dizziness			
Vertigo			
Seizure			
Epilepsy			
Fainting or syncope			
Frequent headaches			
Migraines			
Head injury			
Loss of consciousness			
Concussion			
Memory loss			
Stroke			
Transient ischemic attack (TIA or "mini-stroke")			
Psychosocial	YES	NO	Year and Explanation for Yes Responses
Anxiety			
Depression			
Post-traumatic stress disorder (PTSD)			
Difficulty sleeping			
Suicidal thoughts			
Eating disorder			
CBD use			
Illicit / street drug use			
Alcohol use			
Marijuana / THC use			
Opiate or narcotic use			
Tobacco use including smokeless tobacco			
Vaping			
Other	YES	NO	Year and Explanation for Yes Responses
Stuttering			

Any other injury, symptom, or medical condition not otherwise listed:	
Date:	Condition:
Date:	Condition:
Date:	Condition:
Date:	Condition:

2026 MINOR Driver Statement

Last Name: _____ First Name: _____

I certify that the information I have provided herein, and that I provide in the future to NASCAR Event Management, LLC and its affiliates, and any health care providers, is correct and complete. I further certify that I believe I am physically and psychologically fit to compete in motor vehicle racing in the 2026 season and I have no knowledge of any reason why I should not be allowed to compete. If at any time I do not personally believe that I am physically or psychologically fit to compete for any reason, I will advise the Medical Liaison Department in writing of my concern for my own fitness as soon as possible. I also certify that, should there be any changes in my health status, information, or medications, I will inform the Medical Liaison Department in writing of such change(s) as soon as possible; notification must be made prior to any on-track activity and in no event longer than three (3) calendar days of my discovery of such change(s). Changes to my health status may include but are not limited to illness and / or injuries sustained during or outside of racing activity, diabetes, testosterone deficiency, pregnancy, hypertension, attention deficit / hyperactivity disorder or other acute or chronic conditions requiring medication, treatment, therapy, rehabilitation, or recurring review by medical specialists to obtain clearance to participate in motor vehicle racing activity. I understand that in order to be eligible for a medical waiver for any of the following NASCAR Playoffs or Non-Playoff Series, ("Waiver Eligible Series"), I must inform the Medical Liaison Department, with proper documentation from a relevant medical professional, the medical condition preventing participation in the Event(s).

Waiver Eligible Series:

NASCAR Playoffs Series: NASCAR Cup Series, NASCAR O'Reilly Auto Parts Series, NASCAR Craftsman Truck Series

Non-Playoff Series: ARCA Menards, ARCA East, ARCA West, NASCAR Whelen Modified, NASCAR Canada Series

DRIVER ACKNOWLEDGEMENT: _____ Date: _____

I certify that I am a parent or legal guardian of the above signed minor and authorized by law to sign on the minor's behalf, and that the information provided herein, and that I provide in the future to NASCAR Event Management, LLC and its affiliates, and any health care providers, is correct and complete. I further certify that said minor is physically and psychologically fit to compete in motor vehicle racing in the 2026 season and I have no knowledge of any reason why said minor should not be allowed to compete. If at any time I do not personally believe that said minor is physically or psychologically fit to compete for any reason, I will advise the Medical Liaison Department in writing of my concern for said minor's fitness as soon as possible. I also certify that, should there be any changes in said minor's health status, information, or medications, I will inform the Medical Liaison Department in writing of such change(s) as soon as possible; notification must be made prior to any on-track activity and in no event longer than three (3) calendar days of my discovery of such change(s). Changes to said minor's health status may include but are not limited to illness and / or injuries sustained during or outside of racing activity, diabetes, testosterone deficiency, pregnancy, hypertension, attention deficit / hyperactivity disorder or other acute or chronic conditions requiring medication, treatment, therapy, rehabilitation, or recurring review by medical specialists to obtain clearance to participate in motor vehicle racing activity. I understand that for said minor to be eligible for a medical waiver for any of the following NASCAR Playoffs or Non-Playoff Series' ("Waiver Eligible Series"), I must inform the Medical Liaison Department, with proper documentation from a relevant medical professional, the medical condition preventing participation in the Event(s).

Waiver Eligible Series:

NASCAR Playoffs Series: NASCAR Cup Series, NASCAR O'Reilly Auto Parts Series, NASCAR Craftsman Truck Series

Non-Playoff Series: ARCA Menards, ARCA East, ARCA West, NASCAR Whelen Modified, NASCAR Canada Series

PARENT / LEGAL GUARDIAN SIGNATURE: _____ Date: _____

PARENT / LEGAL GUARDIAN PRINT NAME: _____

ADULT WITNESS SIGNATURE: _____ Date: _____

ADULT WITNESS PRINT NAME: _____

2026 MINOR DRIVER PHYSICAL EXAM

DATE OF EXAM: _____ / _____ / _____

Last Name: _____ **First Name:** _____

*****THIS FORM WILL NOT BE ACCEPTED UNLESS SIGNED BY A LICENSED PHYSICIAN.*****

FOR THIS EXAM, APP (PHYSICIAN ASSISTANT OR NURSE PRACTITIONER) SIGNATURES MUST HAVE PHYSICIAN CO-SIGNATURE.

Examining Physician Name (print clearly): _____

Physician License Number: _____ **State / Prov / Country:** _____ **License Expiration:** _____

Office Address: _____ **City:** _____ **State / Prov:** _____

Zip / Country: _____ **Office Phone:** _____ **Office Fax:** _____

VITAL SIGNS

Date of last Tetanus: _____ / _____ / _____

Height (ft, in)	Weight (lbs)	Temperature (°F)	Blood Pressure	Pulse	Rhythm	Respirations

VISUAL ACUITY	Uncorrected	Corrected	Visual acuity must be 20/40 or better in each eye uncorrected or corrected prior to competition. Visual acuity not meeting this requirement at time of exam requires medical clearance from an optometrist or ophthalmologist.
Left Eye (must be 20/40 or better)	20/	20/	
Right Eye (must be 20/40 or better)	20/	20/	
Binocular (must be 20/40 or better)	20/	20/	

Body System	√ = Normal Exam	Abnormal Findings / Comments
General		
Eyes		
Ears		
Nose		
Oropharynx		
Neck / Thyroid		
Cardiovascular		
Peripheral pulses		
Respiratory		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Extremities		
Back / Spine		
Pelvis		
Skin		
Neurological		
Psychosocial		

The undersigned **Physician** has reviewed the medical history and conducted a thorough physical examination on the patient identified above. As a result of that review and examination, the undersigned **Physician** finds no signs, symptoms or conditions that would preclude the patient from participating in motor vehicle racing. The patient is medically cleared to compete in all motor vehicle racing activities without restrictions.

Physician Signature (required): _____ **Date:** _____

APP Signature (if applicable): _____ **APP Name (Print):** _____ **Date:** _____

APP signature must be accompanied by a physician's signature.

APP License Number: _____ **State / Prov / Country:** _____ **License Expiration:** _____

*****THIS FORM WILL NOT BE ACCEPTED UNLESS SIGNED BY A LICENSED PHYSICIAN.*****

**A CHIROPRACTOR, NMD, or TELEHEALTH DO NOT MEET QUALIFICATIONS FOR THIS EXAM.
APP (PHYSICIAN ASSISTANT OR NURSE PRACTITIONER) SIGNATURES MUST HAVE PHYSICIAN CO-SIGNATURE.**

2026 MINOR DRIVER

Consent for Treatment of Minor

This form is required by NASCAR Event Management, LLC ("NEM") and its affiliates to ensure that all competitors are able to receive proper medical care while participating in sanctioned events and should be returned directly to the Medical Liaison Department prior to the race season. This consent form will allow relevant medical personnel to facilitate care and / or treatment should your minor child / ward become ill or injured as a result of his or her presence and participation sanctioned events. Due to applicable laws across all states / provinces in which events are held, all competitors who are aged 18 and under are considered minors, but determinations of age of consent for purposes of medical treatment may vary by state / province.

To be completed by Parent and / or Legal Guardian

PLEASE TYPE OR PRINT CLEARLY

Minor's Name: _____ Age: _____ Date of Birth: _____

As the parent and / or legal guardian of the minor listed above, I hereby consent to the medical treatment / procedures deemed necessary or advisable by the applicable treating physician(s) and medical team as a result of injury or illness arising out of the minor's participation in any event for which the need for medical care arises.

I understand that medical personnel will attempt to contact me to explain the nature and purpose of any necessary treatment, possible alternative methods of treatment, the risks involved, and the possibility of complications. I understand that there is no guarantee or assurance by anyone as to the results that may be obtained. I also understand some emergency situations may arise where I am unavailable and medical personnel are unable to reach me or may not have time to reach me based on emergency needs of the minor, and I consent to any emergency treatment for the minor that may be deemed necessary in the discretion of such treating medical personnel, regardless of whether the nature and purpose of such treatment, possible alternative methods of treatment, the risks involved, and the possibility of complications have been explained to me or not.

I do hereby agree to indemnify and hold harmless any and all treating physicians, and medical personnel, the hospitals and race track care facilities where treatment may occur, NASCAR Event Management, LLC, and each of its respective parents, subsidiaries, affiliates, members, employees, and their respective subsidiaries, affiliates, agents or representatives who act in reliance upon this authorization.

Parent / Legal Guardian:

Signature: _____ Print Name: _____
Date: _____

Adult Witness:

Signature: _____ Print Name: _____

PARENT AND / OR LEGAL GUARDIAN INFORMATION:

Name: _____ Relationship to Competitor: _____
Home Address: _____
City: _____ State / Prov: _____ Zip: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____

ADDITIONAL PARENT AND / OR LEGAL GUARDIAN INFORMATION:

Is there another parent and / or Legal Guardian of the minor that is legally allowed to make medical decisions for the minor?

No Yes, and their name is:

Name: _____ Relationship to Minor: _____

Home Address: _____

City: _____ State / Prov: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

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

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

This authorization form (“Authorization”) 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”).

The purpose of this Authorization is to review and process my request to participate in sanctioned events or activities. 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 agents, employees, and designees onsite or remotely available at a sanctioned event or activity (collectively “Medical Liaison Department”); (2) NASCAR Event Management, LLC, their affiliates, subsidiaries, agents, members, 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 questionnaires, 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 may also 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, 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, compliance, public health, 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 safety, of safety, compliance, public health, or my assessment, care and treatment; (2) the Medical Review Officer, NEM, and outside experts, engineers, physicians or consultants retained or designated by any of them, for purposes of safety, compliance, public health, 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, 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; they are present at the racetracks to facilitate the sharing of information. This Authorization is being obtained to the extent HIPAA applies to the Medical Liaison Department or others.

(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. Revocation notices for the Medical Liaison Department should be sent to: One Daytona Boulevard, Daytona Beach, FL 32114. 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, 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 the racing series rules and policies will govern whether I may participate in any 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.

MINOR Competitor Signature: _____ **Date:** _____

PARENT / LEGAL GUARDIAN SIGNATURE: _____ **Date:** _____

PARENT / LEGAL GUARDIAN PRINT NAME: _____

ADULT WITNESS SIGNATURE: _____ **Date:** _____

ADULT WITNESS PRINT NAME: _____