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 on December 31, 2020 ("Expiration Date").

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 OCFS Medical Liaison Department and/or their designated agents and employees (collectively "Medical Liaison Department"); and/or (2) Orange County Fair Speedway, their affiliates, agents, employees and consultants (collectively "OCFS") 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 correspondence, patient notes, and phone messages. 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, and that it may include information and records protected under applicable state and provincial law and federal law.*

☐ ***(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, and/or for my 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 my assessment, care and treatment; and/or (2) OCFS, and outside experts, physicians or consultants retained by any of them, for purposes of safety and quality assurance/improvement and making assessments and recommendations related to quality or safety. 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.

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. 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 or health facility may not condition my treatment on whether this Authorization is signed. I understand that OCFS rules and policies will govern whether I may participate in any OCFS-sanctioned event if I choose to revoke this Authorization.

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.

Signature: _____ Date: _____