

# PRO ITALIA LOS ANGELES

## Fastrack Riders Event Registration Form

Please print legibly and either fax to Pro Italia at 818-249-3402 or drop off at our shop at 3319 N Verdugo Road, Glendale, CA 91208. Contact 818 249-5707 or sales@proitalia.com with any questions.

TRACK: **Buttonwillow Raceway Park** EVENT DATE: **Monday, March 12, 2007**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_

PHONES (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ EMERGENCY PHONE \_\_\_\_\_

HEALTH INSURANCE CARRIER \_\_\_\_\_ E-MAIL \_\_\_\_\_

SELECT GROUP (circle one) Check web for pricing	LEVEL 1	LEVEL 2	
LEVEL 3 <b>\$145.00</b>			
\$			
NOVICE SCHOOL Required for all first time on the track riders	<b>Add- \$125</b>		
\$			
RENTALS Leathers - <b>Add \$80</b>	Timer - <b>Add \$20</b>	Boots - <b>Add \$25</b>	\$
Two-On -One Training <b>Add-\$155</b>			\$
		<b>TOTAL:</b>	\$

**FASTRACK RIDERS ASSOCIATION CREDIT & RETURN POLICY**

Fastrack Riders Association reserves the right to change policy without notice. No refunds will be given. Carry over credits will be issued to riders canceling ten (10) days in advance of an event minus a \$50.00 processing fee. The carry over credit will be good for 6 months after your cancellation. All cancellations must be done by phone. There is no cancellation within ten (10) days of an event. If you should cancel within the ten (10) day time frame you will loose all money deposited. In the event of a no-show all money deposited will be forfeited. FASTRACK RIDERS ASSC. has a "Rain or Shine" policy meaning we do not cancel events due to rain or wind. There is a \$50 returned check fee and we will exercise every legal means possible to collect. In addition there is a \$50.00 fee for credit card charge backs. I further agree not to take legal action with respect to payment disputes. There will be no exceptions! Rider grants FRA and its agent's permission to use rider's image and/or likeness in connection with any photograph, video display, or other transmission or reproduction in whole or part of the event.

**FASTRACK RIDERS ASSOCIATION WAIVER OF RESPONSIBILITY**

**Waiver to be signed on separate form at the track on the day of the event**

**CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION**

I hereby consent to the disclosure of information from the patient health care records of the above rider to Fastrack Riders Association, or their representatives, for the purpose of their analysis and use. This consent is for the disclosure of all patient health care records whose confidentiality is protected by Federal laws, as defined in 45 CFR § 164.508 (HIPAA Authorization Requirements for Release of Protected Health Information), 42 CFR Part 2 (Federal Requirements for Release of Alcohol and/or Drug Abuse Program Records), 38 CFR Part 1 (Release of HIV/AIDS, Sickle Cell Anemia, Drug Abuse, Alcoholism or Alcohol Abuse records by the Department of Veteran Affairs), and Secs. 146.81 and 51.30, Wis. Stats. These records include reports and findings relating to care, evaluation, testing, history, progress, diagnosis, prognosis and treatment, including summaries, team conference reports, medical, surgical, pathological, psychiatric, psychological, pharmaceutical, school, vocational, social service, and day service reports. I understand that information disclosed may include reference to or treatment for alcohol/drug abuse, HIV/AIDS and sickle cell anemia diagnoses, and/or emotional illness or developmental disabilities. Records of child and adolescent patients may include reference to parental emotional illness, including the treatment of alcohol and drug abuse. I understand that any HIV/AIDS, sickle cell anemia information, and/or alcohol abuse/treatment information records cannot be re-disclosed without my express written consent or as otherwise permitted by 42 CFR Part 2 or 38 CFR Part 1. A general authorization for the release of medical or other information is not sufficient for this purpose. I further agree that a Photostat copy of this consent shall be considered as effective and as valid as the original. It is my specific intention that this informed consent and request shall be effective for a period of two years or until completion of the purpose for which this consent was given, unless I specifically withdraw this consent in writing. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon this authorization and release of medical records. I also understand that I have the right to refuse to sign this authorization and release of medical records. I understand I may inspect and receive a copy of the disclosed information. I have read all of the above and understand the nature of this release and certify that it accurately reflects my wishes.

**I hereby certify that I have valid medical insurance.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

CHECK \_\_\_\_\_ CHECK # \_\_\_\_\_

CHARGE \_\_\_\_\_ CREDIT CARD EXP DATE \_\_\_\_\_ BILLING ZIP CODE \_\_\_\_\_

CASH \_\_\_\_\_ CREDIT CARD # \_\_\_\_\_

TOTAL \$ \_\_\_\_\_ PROCESSED BY: \_\_\_\_\_