



**FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY**

DISCLAIMER

This authorization template is for general information purposes only. This authorization template provides sample language for covered entities as defined under the Health Insurance Portability and Accountability Act (HIPAA). Data privacy and security laws change frequently. This authorization template is not a substitute for legal advice. You should not use this authorization template without first seeking guidance from your legal counsel.

Participant Name:		
Date of Birth (MM/DD/YYYY):	Phone Number:	
Mailing Address:		
City:	State:	Zip Code:
Email Address:		
Emergency Contact Name:		
Relationship to Participant:	Emergency Contact Phone Number:	

LIVESTRONG® at the YMCA CONSENT AND RELEASE FROM LIABILITY

I hereby consent to voluntarily participate in **LIVESTRONG** at the YMCA with New Canaan Community YMCA (YMCA). I understand the goal of the program is to help adult cancer survivors develop and maintain cardiorespiratory fitness, muscular strength and endurance, flexibility and balance. The program is designed to gradually increase workload on the body to improve overall fitness. The rate of progression is regulated by the rate of my perceived effort of activity. I understand I am responsible for monitoring my own condition throughout the program and should any symptoms occur, I would cease my participation and inform the Instructor and my physician of the symptoms.

I agree to consult my physician and obtain written permission from my physician prior to the commencement of the **LIVESTRONG** at the YMCA Program. I understand the YMCA does not practice medicine and **LIVESTRONG** at the YMCA is not a substitute for the care I receive from my physician or other qualified health care providers. I understand the **LIVESTRONG** Instructor is not a qualified health care professional, does not practice medicine, and support provided by the Instructor is not a substitute for the care I receive from my qualified health care providers.

In consideration for being allowed to participate in this program, I agree to assume the risk of such physical activity, and further agree to hold harmless the YMCA, its employees and agents, from any and all claims, suits, losses or related causes of action for damages, including, but not limited to, such claims that may result in my injury or death, accidental or
FOR INFORMATION PURPOSES ONLY

otherwise, during or arising in any way from my participation in the **LIVESTRONG** at the YMCA Program.

By signing below, I affirm that I have read the above in its entirety, and I understand the nature of the **LIVESTRONG** at the YMCA Program. I also affirm that my questions regarding the program have been answered to my satisfaction.

Signature of participant: _____ Date: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize the new Canaan Community YMCA (YMCA) located at 564 South Avenue New Canaan CT 06840 to collect and use data in connection with my participation in the **LIVESTRONG** at the YMCA Program, maintain this data in a data capture system, and disclose (i.e., share) this data to the YMCA of the USA (Y-USA) located at 101 N. Wacker Drive, Chicago, IL 60606.

Data/Information to be disclosed:

Health information collected in connection with the **LIVESTRONG** at the YMCA Program

The purposes of the disclosure include:

- Program administration, operation, and evaluation
- Research activities approved by an Institutional Review Board (IRB)
- To enter into the YMCA's data system for **LIVESTRONG** at the YMCA for purposes of tracking and verifying health outcomes related to the **LIVESTRONG** at the YMCA Program
- When applicable, to fulfill applicable grant reporting requirements. This may require the re-disclosure of de-identifiable and/or aggregate health information to a third-party, including government entities (e.g., the U.S. Centers for Disease Control and Prevention)

By signing below:

- I authorize the use and disclosure of my health information as described above for the purposes indicated.
- I understand I have the right to receive a copy of this authorization.
- I understand the YMCA will not condition my participation in the **LIVESTRONG** at the YMCA Program on my providing this authorization.
- I understand the YMCA may receive payment or compensation (generally in the form of grants) from Y-USA, and, in some cases, such grants may condition funds on the disclosure of health information to Y-USA.
- I understand that persons or entities that receive health information under this authorization may not be bound by privacy laws (such as the federal law called HIPAA or other state data privacy laws) that protect the health information and, as such, may share it with others without my permission, if allowed by applicable law. Except as

FOR INFORMATION PURPOSES ONLY

explicitly stated in this authorization, Y-USA may not further disclose my health information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

- I understand that I may revoke this authorization at any time by submitting my revocation in writing to the YMCA, and the revocation will not affect information that has already been used or disclosed.
- If this authorization has not been revoked, it will terminate five (5) years after my completion of my last program, unless a shorter period is specified under state law.

Signature of participant: _____ Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION TO HEALTH CARE PROVIDER

I voluntarily authorize New Canaan Community YMCA (YMCA) to release or disclose my protected health information related to my participation in the **LIVESTRONG** at the YMCA Program to my primary care physician and/or other individuals referenced below. I understand I have a right to receive a copy of this authorization, and the information disclosed pursuant to this authorization may be redisclosed by the person(s) listed below. I understand I am not required to sign this form to participate in the program and that I may revoke this authorization at any time by submitting my revocation in writing to the YMCA.

Primary Care Physician Practice:		
Physician Name:		
Address:		
City:	State:	Zip Code:
Phone Number:		Fax Number:
Email:		

Other individual(s)

Name:		
Address:		
City:	State:	Zip Code:

FOR INFORMATION PURPOSES ONLY

Phone Number:	Fax Number:
Email:	

If this authorization has not been revoked, it will terminate five (5) years after your completion of your last program, unless a shorter period is specified under state law.

Signature of participant: _____ Date: _____