FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

LIVE**STRONG®** at the YMCA CONSENT AND RELEASE FROM LIABILITY

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:	

I hereby consent to voluntarily participate in LIVE**STRONG** at the 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 exercise. I understand that I am responsible for monitoring my own condition throughout the exercises 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 LIVE**STRONG** at the YMCA program. I understand the YMCA does not practice medicine and the program is not a substitute for the care I receive from my physician or other qualified health care providers. I understand the LIVE**STRONG** 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 exercise, 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 otherwise, during or arising in any way from my participation in the LIVE**STRONG** 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 LIVE**STRONG** 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 YMCA of Greater Kalamazoo (YMCA) located at 1001 W. Maple St., Kalamazoo, MI., to collect and use data in connection with my participation in the LIVE**STRONG** 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 LIVE**STRONG** at the YMCA Program

The purposes of the disclosure include:

- Program administration, operation, and evaluation
- To transfer to REDCap Online Data Collection System for purposes of tracking and verifying health outcomes related to the LIVE**STRONG** 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 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 that I have the right to receive a copy of this authorization
- I understand that the YMCA will not condition my participation in the LIVE**STRONG** at the YMCA Program on my providing this authorization
- I understand that 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 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 YMCA of Greater Kalamazoo to release or disclose my protected health information related to my participation in the LIVE**STRONG** at the YMCA Program to my primary care physician and/or other individuals referenced below. I understand that 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 that 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:
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: _____