FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

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:	

ENHANCE®FITNESS
CONSENT AND RELEASE FROM LIABILITY

I hereby consent to voluntarily participate in Enhance®Fitness with Lakeland Hills YMCA. I understand the goal of the program is to improve physical strength, increase flexibility and balance, enhance cardiovascular fitness and reduce arthritic pain.

I understand the YMCA does not practice medicine and Enhance®Fitness is not a substitute for the care I receive from my physician or other qualified health care providers. I understand the Enhance®Fitness Instructor is not a qualified health care professional, does not practice medicine, and that support provided by the Instructor is not a substitute for the care I receive from my physician or other 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 otherwise, during or arising in any way from my participation in Enhance®Fitness.

By signing below, I affirm that I have read the above in its entirety and I understand the nature of Enhance®Fitness. I also affirm that my questions regarding the program have been answered to my satisfaction.

Signature of participant: _____ Date: _____

FOR INFORMATION PURPOSES ONLY

AUTHORIZATION FOR
USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize the Lakeland Hills YMCA located at 100 Fanny Road to collect and use data in connection with my participation in Enhance®Fitness, 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 Enhance®Fitness

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 Enhance®Fitness for purposes of tracking and verifying health outcomes related to Enhance®Fitness
- When applicable, to fulfill applicable grant reporting requirements. This may require the re-disclosure of de-identified 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 that I have the right to receive a copy of this authorization.
- I understand the YMCA will not condition my participation in Enhance®Fitness 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 disclose it to other persons or entities without my permission, if allowed by applicable law. Except as 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 completion of your 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 Lakeland Hills YMCA to release or disclose my health information related to my participation in Enhance®Fitness 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 that 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:
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: _____

FOR INFORMATION PURPOSES ONLY