FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION BLOOD PRESSURE SELF-MONITORING

Please complete all sections, date, and sign.

Participant Name:	**Date of Birth:**
Address:	

I voluntarily authorize (*i.e.*, permit) the use and disclosure of my health information, which includes but is not limited to name, address, and the fact that I have a medical condition that qualifies me for a program set forth below.

This information is to be used or disclosed by:	**And is to be provided to:**
YMCA Name: _____ ("YMCA")[1]	YMCA of the USA (Y-USA)
Address: _____	101 N. Wacker Drive
City/State/Zip: _____	Chicago, IL 60606

[1] The programs provided by the YMCAs are layperson led and are not directed by licensed health care providers. Although it is our position that the YMCAs are not subject to the Health Insurance Portability and Accountability Act, as they are not health care providers, this form, in an abundance of caution, is designed to comply with that law and its requirements.

Information to be used and disclosed:

Health information collected in connection with Blood Pressure Self-Monitoring

The purposes of the uses and disclosures include (check all that apply):

☐ To bill third-party payors, including commercial insurance plans and government programs, for services.

☒ Program administration, operation, and evaluation.

☐ To fulfill applicable grant reporting requirements. This may require the re-disclosure of health information to a third-party, including government entities (*e.g.*, the Centers for Disease Control and Prevention ("CDC") or the Centers for Medicare and Medicaid Services ("CMS")).

☐ For use by our vendors that provide services to us in connection with the operation of our programs.

☒ To transfer to REDCap Online Data Collection System for purposes of tracking and verifying health outcomes related to Blood Pressure Self-Monitoring.

☒ To share with participant's primary care physician.

☐ For use by Y-USA's vendors that provide services to us and/or the YMCA. For example, in billing third-party payors, such as health plans, for the services we provide to you, Y-USA may sub-contract with a third-party medical billing company to process claims on our behalf.

☒ For uses and disclosures authorized or required by law.

By signing this authorization:

- I authorize the use and disclosure of my health information as described above for the purposes indicated.
- I understand that I can revoke (*i.e.*, take back) this authorization at any time. The revocation must be made in writing to the YMCA's privacy officer or other YMCA staff member responsible for privacy, _____ [INSERT NAME], and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that YMCA will not condition treatment, payment, enrollment or eligibility for benefits on my providing this authorization.
- I understand that 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 required by privacy laws (such as the federal law called HIPAA) to protect the information and may share it with others without my permission, if allowed by laws applicable to them. 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.
- 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:**
Signature of Personal Representative:	**Date:**
If signed by a personal representative, state relationship to participant (e.g., parent, guardian, etc.):	