YMCA OF THE TRIANGLE
USE AND DISCLOSURE OF MY HEALTH INFORMATION BY THE YMCA OF THE TRIANGLE *MEDICAL MEMBERSHIP*

I understand that it is important for me to define and to understand how the health information about me that is gathered during my participation in the YMCA Medical Membership Program will be used by YMCA Medical Membership staff and how and when it will be disclosed to others outside the YMCA.

The information I provide will be used by the YMCA to guide and direct how the YMCA uses my health information and discloses it.

I understand that it is important that other YMCA programs in which I participate should have access to my health information from Medical Membership and I will provide authorization of this Use and Disclosure agreement along with my allowed contact and communication methods to make that clear

I also understand that it will be essential that information about my progress in the Medical Membership should be available to my family doctor, and to others who are providing treatment to me, so the physician and other health care organizations I provide will receive all information about my progress in the Program:

The purposes of the disclosure include:

Program administration, operation, and evaluation.

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)

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

1. I authorize the YMCA to enter my protected Health Information into a secured HIPAA compliant electronic health record for the purpose of tracking and verifying my participation in the Medical Membership evidence based program and having it available for further use and disclosure as described below in this Authorization.
2. I authorize the persons working in the Medical Membership evidence based programs to use and disclose my personal, physical, or health information for the purpose of furnishing data needed by those YMCA staff members who are providing service to me in any other YMCA programs in which I participate, this includes YUSA reporting for any grant related work in secured databases.
3. I understand that any personal health information that is disclosed under this authorization may be subject to re-disclosure by a recipient of the data.
4. By participating in Medical Memberships, I have access to YMCA membership, which discloses Medical Membership participation.
5. I authorize the persons working in the Medical Membership to disclose de-identified Health Information for the sole purpose of aggregate reporting on program outcomes to YMCA community partners and donors.
6. I have a right to receive a copy of this authorization. I also understand that I may cancel this authorization at any time by providing written notice of cancellation emailed to the Medical Membership coordinator. However, due to the reporting requirements for Medical Membership that are imposed on the YMCA, and the need to coordinate the services provided to me by the YMCA, if I cancel this authorization, I will not be able to continue to participate in Medical Membership. Should you choose not to sign this authorization, we will consult with our hipaa compliance officer on how to best serve you through programming if feasible, and YMCA required grant reporting.
7. 7. This authorization will automatically terminate at any point that I give notice to the YMCA that I am discontinuing my participation in Medical Membership. I understand that aggregate data will continue to be reported. 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.
8. I acknowledge and understand that my participation in a Medical Membership evidence-based program may occur if I participate in additional YMCA programs (such as personal or group training classes). As a result, while I participate in additional services, I may receive guidance or services from YMCA staff members who are not directly involved in the Medical Membership, but who may need access to health information about me that is held by Medical Membership in order to provide those other YMCA services to me safely and effectively.

RECEIPT OF YMCA'S PRIVACY PRACTICES AND ASSIGNMENT OF BENEFITS FORM FOR BLUE CROSS BLUE SHIELD NC BENEFICARIES ONLY

I acknowledge that the YMCA will report to BCBS the Medical Membership impact report on my behalf to YMCA regarding my Medical Membership participation. **This will NOT be a claim but a grant report on the work that the YMCA has completed to improve community health initiatives**.

I certify that I have active and valid insurance coverage and have supplied YMCA with the up-to-date and correct insurance identification card as well as supplied YMCA all necessary information. It is my responsibility to notify YMCA of any changes in my health care coverage. Failure to provide correct information to the YMCA may result in denial of discounted YMCA membership that it will be my responsibility to pay YMCA for those services rendered to me.

I certify that the information I have reported with respect to my insurance coverage is correct and current, and I hereby authorize YMCA the release of any information necessary to process Medical Membership reporting and to suffice partnership impact reports. The original authorization will be kept on file by YMCA; provided, however, that a copy of this authorization may be used in place of the original. I understand and acknowledge that I may revoke this authorization at any time in writing