FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CONSENT TO RELEASE HEALTH INFORMATION TO HEALTH CARE PROVIDER

I consent to__________________________(the "YMCA") disclosing my child's (named below) personal identifiable information related to their participation in the YMCA's Healthy Weight and Your Child Program to their Primary Care Physician and/or other individuals referenced below.

Participant's [Child] Name: ________________________________

Child's Date of Birth: ______/______/________

The information that will be used or disclosed will consist of health-related information relevant to or arising out of participation in the YMCA's Healthy Weight and Your Child Program. It will be disclosed to the person(s) listed below at my request. I understand that I am not required to sign this form in order for me or my child to participate in the YMCA's Healthy Weight and Your Child Program and that the information disclosed pursuant to this consent may be redisclosed by the person(s) listed below.

Primary Care Physician or Practice: ____________________________________

Physician: ____________________________________

Address: ____________________________________

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Phone Number: ____________________________________

Fax: ____________________________________

Other Individuals: ____________________________________

I understand that my consent is voluntary and that I may revoke this consent at any time by submitting my revocation in writing to the YMCA. This consent will expire upon termination of my child's participation in the YMCA's Healthy Weight and Your Child Program.

____
Parent/Caregiver Name (Print)

____ ____________________________
Parent/Caregiver Signature Date