AUTHORIZATION FOR RELEASE OF INFORMATION TO HEALTH CARE PROVIDER

I voluntarily authorize the YMCA of Greater Waukesha County (YMCA) to release or disclose my protected health information related to my participation in the Cardiac Rehab Maintenance Program to my primary care physician and/or other individuals reference below. I understand that I reserve the 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 sumbitting 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If this authorization has not been revoked, it will terminate five (5) years after your completion of your last program, unless a shorter period is specified under state law.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: _____