Montefiore
THE UNIVERSITY HOSPITAL FOR
ALBERT EINSTEIN COLLEGE OF MEDICINE

Montefiore Associate Wellness Program

Health Information Release
I _____ MUST obtain patient authorization to release this information to the YMCA (*see reverse [page 2] to obtain the Authorization to Release Health Information*).

Patient Name: _____ Date of Birth:_____

Phone: _____ Email: _____

Spanish Speaking Required: ___Yes ___No Sex: ____M ____F _____other

Availability for Class (please complete fields below):

Campus preference(s): _____

___Mondays (_____) ___Tuesday (_____) ___Wednesday (_____)

___Thursday (_____) ___Friday (_____) ___**Weekend** (_____)

Body Mass Index (to qualify, BMI must be ≥25)
Height: _____ inches Weight: _____ pounds BMI: _____ kg/m$_2$

If you are of Asian descent then you qualify with a BMI ≥ 22. Check here if this applies to you: ☐

Pre-Diabetes Criteria (patient must meet one) (*check all that apply AND enter value*)*:
____ Fasting plasma glucose (FPG) between 100-125 mg/dL _____ mg/dL
____ 2-hour plasma glucose (OGTT) between 140-199 mg/dL _____ mg/dL
____ Hemoglobin A1C between 5.7%–6.4% _____ %
Date of lab results: _____

Referring Provider Information

Provider Name: _____ Provider Signature: _____

Date: _____ Provider Phone: _____

Provider department: ____AW Nutrition ____Care Guidance ____OHS ____Other

*If you do not have current lab values qualification can be determined by the YMCA Risk Score Calculator

Please send this completed form to Montefiore Associate Wellness
Email: wellnessRD@montefiore.org; Fax: 914-378-6053 ATTN: Associate Wellness RD
If you have any questions please contact the Associate Wellness Dietitian at Phone: 347-504-4944

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

To be completed by associate

I agree and request that the health information listed below be released to the YMCA for the purpose of referring me to the YMCA's Diabetes Prevention Program. The specific information to be released are:

- My demographic information (name, date of birth, contact phone and/or email, gender and language preference)
- My body mass index (BMI) including my height and weight
- My blood test results

I have the right to revoke this authorization at any time by writing to the Office of Community and Population Health (718) 920-4077 or communityhealth@montefiore.org , except to the extent that action has already been taken based on this authorization. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. I understand that information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law. This authorization will be in effect until (a) I am no longer enrolled/participating in the YMCA's Diabetes Prevention Program or (b) I expressly revoke the authorization (in writing).

Patient name (print): _____

Signature: _____ Date: _____

Office Use Only

Referral Source (circle one): Tabling E-mail Other: _____

Campus of Referral (circle one): Moses Einstein Wakefield Other: _____

Please retain this page for Montefiore Records-this is not to be faxed!