

**Your Name (first and last):**

**Your Contact Number:**

**Your Email:**

**Emergency Contact Name (first and last):**

**Emergency Contact Number:**

**Do we have permission to send you updates about new online programs and resources through COVID-19 shelter in place period?:**

**Confidentiality Agreement**

This form is a confidentiality agreement. As a candidate of this Online Group, the following information

must be agreed and adhered to in order to participate in the Online Group:

• You are participating in this group voluntarily.

## You may stop attending this group at any time.

## Please provide ample notice to the group leader, if you choose to discontinue attendance.

#**# If you violate any of the terms of this agreement, as deemed by the group leader(s),**

**Stanford Health Care (SHC) or its affiliates, it shall be grounds for expulsion from the**

**Online Group.**

• Sharing of information is also voluntary.

## The group format involves sharing information to help yourself and others in the group.

## You may choose to share as much or as little as you feel comfortable with during each session.

## Any information shared by you and others is confidential.

Do not share this information outside of the group setting, except in an individual

meeting with your group leader.

**• As a participant, you agree to not disclose any information to those outside of the group**

**that may reasonably be used to identify another member of the group.**

• You agree to not record any voice conversations, videos, and/or create still images (e.g., take

pictures) of any information shared in the Online Group by the use of any recording device,

application, or otherwise.

## Any member discovered to have any such recordings will be asked to delete those

recordings. **Additionally, any member discovered to begin, or have in their possession,**

**any such recordings will be removed from participating in the Online Group.**

## If in the future, group leader(s), SHC, and/or its affiliates, chooses to record group sessions,

you shall:

Receive reasonable notice of SHC’s intent to record group sessions; and

Be given an opportunity to opt out of the Online Group, so as to not be recorded.

• If you choose to opt out of the Online Group, you are not guaranteed placement in a

comparable Online Group.

• The leader(s) of this Online Group, as well as SHC and its affiliates, must adhere to

professional and ethical guidelines related to confidentiality, as well as state and federal laws

governing confidentiality and patient privacy. SHC and its affiliates reserve the right to make

disclosures of any information gathered in the Online Group in a manner which is consistent

and/or otherwise required by applicable state and federal laws.

• You agree to hold harmless SHC, and its affiliates, in any and all claims related to misuse and/

or misappropriation of your personal and/or protected health information, shared during Online

Group sessions, by another group member or persons who obtain your information through

another group member.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Education Program Participation Agreement**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am voluntarily enrolling and participating in a class or activity hosted by Stanford Health Care, including but not limited to, aerobic exercises, balance and functional movement practice, yoga, dance, resistance strength conditioning, and/or tai chi. I am aware of the risks and hazards involved in participating in a class or activity where there is chance for injury. I understand that it is my responsibility to consult with my physician regarding, and prior to my participation in, any type of class or activity at Stanford Health Care. I hereby affirm that I am in good physical condition and do not suffer from any disability or condition that would prevent or limit my participation in classes or activities.

In the event of any unusual pain, discomfort, injury, light headedness or dizziness during the class or activity, I will cease participation. I understand I am responsible for modifying exercises as necessary based on my physical condition and/or state of being.

I understand that Stanford’s Health Education Programs, in an effort to provide me with the latest program updates on exercise classes and activities, care, and research, will communicate with me by email or text. At any time, I may change my communication preferences and opt out of email or text communications by contacting Stanford’s Health Education Program.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fill out this form and return to [CancerSupportiveCare@StanfordHealthCare.org](mailto:cancersupportivecare@stanfordhealthcare.org). Thank you!