



PERMISSION WAIVER/ CONFIDENTIALITY/BEHAVIORAL STANDARDS ACKNOWLEDGMENT FORM

Confidentiality Agreement

HIPAA: The "Health Insurance Portability and Accountability Act" of 1996 (Public Law 104 - 191) has been enacted to protect patient confidentiality across the continuum of care provided to medical recipients. My signature confirms I understand that all information, including patient names, diagnosis, treatment, or any item pertaining to patients, is confidential and prohibited from disclosure and protected by law if released without proper consent. Memorial Health System business information, including but not limited to financial, employee, and business partners information is rightfully so confidential and prohibited from unauthorized disclosure. I understand I am prohibited from gaining unauthorized access to or making any disclosure of such information without appropriate consent and authorization of the person to whom the information pertains and hereby agree to maintain the confidentiality of such information with my signature below.

Behavioral Standards

Behavioral standards have been adopted by all MHS employees and developed to maintain a sharp, clear focus on what we are here to do, which is to improve the health of the people and communities we serve. Our guests are expected to maintain the same standards while developing their career experience.

Behaviors

1. Positive Attitude. Contribute to a positive atmosphere.
2. Customer Service. Exceed expectations and put others first.
3. Courtesy and Respect. Be courteous, safe and listen closely.
4. Communication. Introduce yourself and communicate clearly.
5. Professional Conduct. Respect patient privacy and follow policies and procedures.
6. Team Work. Help others and perform work in a timely manner.
7. Professional Appearance. Wear badges for identification and maintain professional appearance.

Inappropriate behavior will be addressed on an individual basis. Guests who are being disruptive or disrespectful for a professional work environment will be asked to discontinue participation for remainder of session.

Emergency Contact

In the event of an emergency, please contact: _____ at _____
Contact name Phone number(s)

In the event my emergency contact cannot be reached by telephone, I grant permission to the sponsoring organizations to provide appropriate measures of medical care as deemed necessary by certified / licensed medical staff, with follow-up care by a licensed physician if necessary.

Release of Liability and Consent to be Photographed

My signature confirms I am in agreement with the policies set forth and will comply with requested guidelines. I understand there is some risk with this type activity to include but not be limited to fainting, site of blood or trauma, site of nudity, site of altered state of consciousness, and/or exposure to illness, infection and or injury within a clinical working environment and hereby assume the responsibilities of the potential risks. I also understand and authorize Memorial Health System to photograph, film, videotape, and/or interview me while participating in the program. I hereby release and agree to indemnify and hold harmless Memorial Health System, its affiliates, and their trustees, officers, employees, agents, patients, and medical staff from any injury and/or damages sustained as a result of such photographing, filming, videotaping, and/or interviewing, including, but not limited to, claims for personal injury, property damage, invasion of privacy and/or breach of confidentiality. THIS IS A LEGAL CONSENT FORM AND RELEASE OF LIABILITY. PLEASE READ IT CAREFULLY AND BE SURE YOUR QUESTIONS HAVE BEEN ANSWERED BEFORE SIGNING.

Permission Waiver, If Under 18

I hereby give permission for _____ (Name of Minor) to participate in Workforce Development Programs with Memorial Health System.

Parent/Guardian signature

Participant signature

Date
171-0272 08/01/19