THOMPSON HEALTH | An Affiliate of the University of Rochester Medical Center

CONFIDENTIALITY STATEMENT

As a student visitor at Thompson Health, I understand that I will be working with or have access to patient/resident and/or associate information which is confidential. Federal and State statutes and regulations protect the private and confidential nature of patient/resident and/or associate information records.

Moreover, due to the ethical standard of a patient's, resident's and associate's right of privacy, I understand that information I may be exposed to during the course of my day may not be discussed outside the facility or with others within the facility who do not need to know the information for any business or patient/resident care reason.

I understand and agree to the following:

- To pledge not to give out any information concerning a patient seen during my visit, observation and/or job shadowing, to any person (HIPAA-Health Information Privacy rules).
- To understand that the health care facility shall retain through the department in which the shadowing occurs, all professional and administrative responsibility for services rendered to patients under the facility's care.
- To understand that I must meet the practices and principles required while I'm observing an area or department of the health care facility.

Participant Name (Printed & Signed) _____ Date _____

Parent or Guardian's Signature (if under 18 years of age) _____

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Photographing Authorization

By signing this agreement with Thompson Hospital, you are allowing your child to be photographed or permit other persons to photograph for the purpose of: news releases and/or public relations to include: story boards, brochures, any other informational purposes in the promotion of Thompson Health's Career Exploration Day.

Parent Signature _____ Date _____