FHN Confidentiality Statement and Participation Release

During this learning opportunity, I recognize that I am a guest of FHN. I understand that it will be my responsibility to dress in an appropriate manner and to behave professionally regardless of the health care area I might be visiting. **I also understand** that if, in the opinion of FHN staff, I am unable to comply with these requirements, I may be asked to leave the premises without completing my learning opportunity.

I understand that all patients have a right to privacy and to the confidentiality of their protected health information (PHI) which must be respected. Therefore, I agree that I will not access or obtain any PHI except that which is necessary for the learning opportunity in which I am participating and then only to the extent allowed by FHN in connection with that learning opportunity. I will not otherwise seek or obtain confidential information in regard to a patient and/or any other PHI. I will maintain all PHI in the strictest of confidence and will not reveal any PHI that I may learn to anyone other than an employee of FHN working with that patient; I agree that this obligation continues both during my learning opportunity and after the learning opportunity has ended. **I also understand** that if I am in violation of this provision, in the opinion of FHN staff, I will be asked to leave the premises without completing my learning opportunity.

I understand that any non patient-related information that I may learn which pertains to the business and operations of FHN and its business units must remain confidential while I participate in this learning opportunity and indefinitely once my learning opportunity has ended.

I further understand that any violation of confidentiality will result in my immediate removal from this learning opportunity. Any other problems with my performance may lead to my dismissal as well.

_____
Initial

I, _____hereby acknowledge that I have chosen to participate in a learning activity provided by
(name of participant)
FHN. If at any time during this opportunity I sustain an injury of any type, I authorize FHN and its employees to contact the following individuals to notify them of the emergency.

Name	Relationship	Phone Number

I agree not to sue and to release, indemnify and hold harmless, FHN, its affiliates, officers, directors, volunteers and employees from any and all liability, claims, demands, and causes of action of any type whatsoever, arising out of or in connection with, either directly or indirectly, my participation in this learning activity.

By signing this Agreement, I am stating that I understand <u>ALL</u> the above information and am willing to accept these responsibilities. I also authorize FHN to render to me any emergency aid or treatment deemed necessary to treat this injury.

Participant's Signature	Date	FHN Location

Parent/Guardian's Signature (if participant is under 18)	Date	Dates of Observation

FHN Representative	Date	School Affiliation & Program

<u>Please check the box that is appropriate:</u>

☐ Job Shadow ☐ Internship/Externship ☐ Pre-employment Observation ☐ Scholastic Observation/Project

Return completed form to FHN Human Resources

Reviewed 7/2019
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