Attachment D

Shadow/Observation Confidentiality Agreement

I,_____, acknowledge that during my shadow/observation experience at Tomball Regional Medical Center , I agree to keep all information in strict confidence and will not disclose or disseminate any confidential information that I may be exposed to. I understand that I am obligated to maintain patient confidentiality at all times, both at the facility and when away.

I understand that all the medical information/records regarding a patient are confidential. This information will not be given to other individuals, unless proper authorization is obtained. I understand that it is not appropriate to discuss any patient's care and treatment in public places or with people that have not been involved in the case nor have reason to know details of the patient's health care. I also agree that I will not share conversations I hold with any healthcare provider during the course of the observation experience. I further agree that I will not take pictures or share information on any social network web site or in emails.

I understand that all patient, associate and/or organizational information, (financial and/or clinical), retrieved from any and all computer system(s) is strictly confidential. It should not be reproduced, transmitted, transcribed, or removed from the premises in any form.

I understand that any deviation from the above could result in legal action against the organization and me. I further understand that any breach of confidentiality, intentional or unintentional may result in immediate termination of my shadow/observation experience and deny any future opportunities.

My signature below certifies that all of the above confidentiality considerations have been explained to me and I was afforded the opportunity to ask questions.

Signature of Observer _____ Date_____