



Release of Liability

You have been approved to participate in an educational experience, group/individual tour, visit at Driscoll Children's Hospital. Please read the following information carefully and return this form to Driscoll Children's Hospital, Volunteer Department, 3533 S. Alameda, Corpus Christi, Texas 78411 or fax to 361-808-2096 prior to your scheduled date.

I do hereby agree to assume the entire risks attendant to such activity, including motor vehicle accidents on streets, ways or private property. I do hereby release and forever discharge the hospital, their employees, agents, Leases, contractors, and concessionaires, in both their public and private capacities on and from any and all liability, claims, suits, damage, or causes of action what so ever for any property damage or personal injury sustained or that may arise in any manner in connection with taking part in the shadowing experience, group/individual tour or visit. I will assume all responsibilities related to accidents or other difficulties.

I acknowledge that I am responsible for transportation to and from the hospital where I will be participating in this experience. I have read this Consent and Release of Liability form, and fully understand these terms and conditions, and further understand that the opportunity to participate is based on the signing of this document.

SIGNED this the _____ day of _____, 2_____.

Signature of Participant

Guardian's Signature (for minor)

Printed Name of Participant

School/Affiliation Agency: _____

Name of employee you shadowed: _____

**DRISCOLL CHILDREN'S HOSPITAL (DCH)
HEALTH INFORMATION CONFIDENTIALITY AGREEMENT**

This Health Information Confidentiality Agreement ("Agreement") applies to all members of the DCH workforce including medical staff, employees, volunteers, independent contractors, trainees and others who, in the performance of work for DCH, are under DCH's direct control and who have access to protected health information ("PHI") maintained, received, or created by DCH.

Please read all sections of this Agreement, in addition to DCH's privacy and security policies and procedures, before signing below.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, DCH has a legal and ethical responsibility to take certain administrative safeguards that protect the privacy of all DCH patients and that protect the confidentiality of their health information. In the course of your employment, whether or not you are directly involved in providing patient services, you may hear information that relates to a patient's health, read or see computer or paper files containing PHI and/or create documents containing PHI. Because you may have contact with PHI, DCH requests that you agree to the following as a condition of your employment:

1. Confidential PHI

I understand that all health information that may in any way identify a patient or relate to a patient's health must be maintained confidentially. I will regard confidentiality as a central obligation of patient care.

2. Prohibited Use and Disclosure

I agree that, except as required under my job responsibilities or as directed by DCH, I will not at any time during or after my work for DCH speak about or share any PHI with any person or permit any person to examine or make copies of any PHI maintained by DCH. I understand and agree that personnel who have access to health records must preserve the confidentiality and integrity of such records, and no one is permitted access to the health record of any patient without a necessary, legitimate, work-related reason. I shall not, nor shall I permit any person to, inappropriately examine or photocopy a patient record or remove a patient record from DCH.

3. Safeguards

When PHI must be discussed with other healthcare practitioners in the course of my work for DCH, I shall make reasonable efforts to avoid such conversations from being overheard by others that are not involved in the patient's care.

I understand that when PHI is within my control, I must use all reasonable means to prevent it from being disclosed to others, except as otherwise permitted by this Agreement. I will not at any time reveal to anyone my confidential access codes to DCH's information systems, and I will take all reasonable measures to prevent the disclosure of my access codes to anyone. I also understand that DCH may, at any time, monitor and audit my use of the electronic/automated patient record and information systems.

Protecting the confidentiality of PHI means protecting it from unauthorized use or disclosure in any form: oral, fax, written, or electronic. If I keep patient notes on a handheld or laptop computer or other electronic device, I will ensure that my supervisor knows of and has approved such use. I agree not to send patient identifiable health information in an email, or email attachment, unless I am directed to do so by my supervisor.

4. Training and Policies and Procedures

It is my responsibility to read DCH's policies and procedures, complete the training courses offered by DCH, and abide by DCH's policies and procedures governing the protection of PHI.

5. Return or Destruction of Health Information

If, as part of my job responsibilities, I must take PHI off the premises of DCH, I shall ensure that I have DCH's permission to do so, I shall protect the PHI from disclosure to others, and I shall ensure that all of the PHI, in any form, is returned to DCH or destroyed in a manner that renders it unreadable and unusable by anyone else.

6. Termination

At the end of my employment with DCH, or when my assignment for DCH is otherwise terminated, I will make sure that I take no PHI with me, and that all PHI in any form is returned to DCH or destroyed in a manner that renders it unreadable and unusable by anyone else. Discharge or termination, whether voluntary or not, shall not affect my ongoing obligation to safeguard the confidentiality of PHI and to return or destroy any such PHI in my possession.

7. Sanctions

I understand that my unauthorized access or disclosure of PHI may violate state or federal law and cause irreparable injury to DCH and harm to the patient who is the subject of the PHI and may result in disciplinary and/or legal action being taken against me, including termination of my employment.

8. Reporting of Non-Permitted Use

I agree to immediately report to DCH any unauthorized use or disclosure of PHI by any person. The person to whom I report unauthorized uses and disclosures is Aaron Childress at 361-694-6720.

9. Disclosure to Third Parties

I understand that I am not authorized to share or disclose any PHI with or to anyone who is not part of DCH's workforce, unless otherwise permitted by this Agreement.

10. Agents of the Department of Health and Human Services

I agree to cooperate with any investigation by the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any agent or employee of HHS or other oversight agency, for the purpose of determining whether DCH is in compliance federal or state privacy laws.

11. Disclosures Required by Law

I understand that nothing in this Agreement prevents me from using or disclosing PHI if I am required by law to use or disclose PHI.

By my signature below, I agree to abide by all the terms and conditions of the Health Information Confidentiality Agreement.

Employee/Volunteer/Visitor/Student Signature: _____

Printed Name: _____

Department/Program (Circle One): Shadowing _____ Tour/Visit _____

Date: _____

The name of the employee you shadowed: _____