

HIPAA and Confidentiality

Form B

I understand the importance of maintaining the privacy of all confidential medical information I may encounter during my job shadowing experience and agree to maintain patient confidentiality. I recognize that I may be exposed to potential risks as a result of this activity and will not hold OrthoNebraska liable for any risks as a result of this activity.

- I understand that during and following my job shadow experience, patients' names and illnesses are never to be mentioned to anyone inside or outside of the OrthoNebraska, except to the staff member or provider I am shadowing with.
- I understand that I should not read any paper or other record relating to a patient unless specifically directed to by the staff member or provider with whom I am shadowing. I will follow directions carefully.
- I agree to follow all the job shadowing guidelines shared with me. I understand that I may be withdrawn from participation at any time by the staff member or provider if in his/her sole discretion it is determined it to be in the best interest of OrthoNebraska or its patients.

Name (Print)

Signature

Date

Job Shadow Code of Conduct

As a participant in the OrthoNebraska Job Shadowing program:

1. I will arrive promptly.
2. I will behave in an appropriate, and courteous manner at all times.
3. I will dress and act professionally.
4. I will respect patient's right to refuse to have an observer present.
5. I will maintain strict confidentiality and privacy about patient information.
6. I will treat all patients and staff with respect and dignity, regardless of age, gender, race, ethnicity, national origin, religion, disability, or sexual orientation.
7. I will be respectful in my interactions with patients, providers, and other staff members.
8. I understand this experience is observational only. I will not touch the patients or medical equipment.
9. I understand I do not have medical record or chart access. Job shadow participants are not permitted to review medical records at any time during their shadowing experience.
10. I understand that I am to leave all valuables at home.
11. I understand that any use of a cellular device is prohibited.
12. I understand I am to remain home if I am ill; and will notify the job shadowing coordinator of my absence.
13. I will not approach physicians about personal illness or medications.
14. I will not be permitted in areas of contamination such as isolation rooms, soiled linen areas, or sterile processing.
15. I understand that the appropriate accident and liability insurance coverage is my responsibility.

Name (Print)

Signature

Date

Parental/Guardian Participation Consent

If participant is not 19 years of age

(Name) _____ has my permission to participate in the job shadowing experience offered by OrthoNebraska. I have reviewed the job shadowing guidelines with my child, stressing the importance of maintaining the code of conduct and privacy of all confidential medical information he/she may encounter during the course of his/her job shadowing experience. I recognize that job shadowing offers a significant benefit to my child in terms of first-hand exposure to potential career opportunities in the medical field. In consideration for this benefit, I agree to hold harmless and indemnify OrthoNebraska from any liability arising from my child's failure to abide by OrthoNebraska's policies concerning the privacy of confidential medical information.

Parent/Guardian Signature

Relationship to participant

Date

Revised April 2022.

Nebraska Orthopaedic Hospital, LLC and OrthoWest, PC are each operating under the name OrthoNebraska. For more visit OrthoNebraska.com/legal.