

## Student Observation Request Form

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Student email address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

School: \_\_\_\_\_ Level of Student: \_\_\_\_\_

Faculty Member Name: \_\_\_\_\_

Faculty Member email address: \_\_\_\_\_

Faculty Member Phone #: \_\_\_\_\_ Emerg Phone#: \_\_\_\_\_

Date/Time Requested: \_\_\_\_\_

Area Requested: \_\_\_\_\_ Hours/Shift Requested: \_\_\_\_\_

Second Choice: \_\_\_\_\_ Shift: \_\_\_\_\_

Third Choice: \_\_\_\_\_ Shift: \_\_\_\_\_

### **Student Must:**

- 1) Attach the **signed** Exhibit A form to this request signed by you and the school official.
- 2) Attach a copy of your objectives for this experience to this request or write purpose on back of this form. The objectives and Exhibit B **must be signed by your instructor.**
- 3) Complete Tenet HIPAA training at the site below:  
[Hhttp://www.tenethealth.com/about/pages/InformationPrivacySecurityandHIPAATraining.aspx](http://www.tenethealth.com/about/pages/InformationPrivacySecurityandHIPAATraining.aspx). Print certificate of completion and give to instructor to keep on file at school.

Send completed form and attachments to:

Carolyn Chalkley, RN, MSN  
Coordinator, Academics  
Brookwood Medical Center  
2010 Brookwood Medical Center Drive  
Birmingham, Alabama 35209  
Phone: 205-877-1665  
Fax: 205-877-1958  
carolyn.chalkley@tenethealth.com

### **To Be Completed By Coordinator:**

Area/preceptor assigned: \_\_\_\_\_

\_\_\_\_\_



**Exhibit A**  
**Observation Only**

**Responsibility And Confidentiality Statement**

For and in consideration of the benefit provided the undersigned in the form of experience in evaluation and treatment of patients of **BROOKWOOD MEDICAL CENTER** ("Hospital"), the undersigned and his/her heirs, successors and/or assigns do hereby covenant and agree to assume all risks of, and be solely responsible for, any injury or loss sustained by the undersigned while participating in the **observation** at Hospital unless such injury or loss arises solely out of Hospital's gross negligence or willful misconduct.

My sponsoring facility, academic facility, employer or I have personally provided evidence of my professional and/or general liability insurance to the Hospital department authorizing my observation activity.

If I do not provide evidence of insurance, I am personally liable for all injury, illnesses, or damages to myself or others related to my participation in this event. I hereby release, hold harmless, acquit, and forever discharge Brookwood Medical Center, Brookwood Health Services, Inc., Brookwood Center Development Corporation, Tenet Health Care Corporation, and each of these entities, their agents, servants, successors, or assigns, for any and all actions, causes of action, claims, demands, damages, costs, expenses, any present or future healthcare charges related or unrelated to medical treatment and compensation, arising out of, or related in any way to my observation in patient care areas in this Hospital or its associated entities.

In addition, the undersigned agrees to:

1. Abide by the Policies and Proceedings of the Hospital;
2. Comply will all applicable federal, state and local statutes and regulations in connection with the observation;
3. Obtain prior written approval from the Hospital before publishing any materials relating to the observation.

The undersigned hereby acknowledges her/her responsibility under applicable Federal law to keep confidential any information regarding Hospital patients, as well as all confidential information of Hospital. The undersigned agrees, under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient and further agrees not to reveal to any third party any confidential information of Hospital, except as required by law or as authorized by Hospital.

Dated this \_\_\_\_\_ day of 200

\_\_\_\_\_  
Observation Participant

\_\_\_\_\_  
School Official Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
School Official Name, Title,

\_\_\_\_\_  
Phone, Email



## Exhibit B Confidentiality Statement

### The Health Insurance Portability and Accountability Act Privacy Regulations

As of April 14, 2003, the federal Health Insurance Portability and Accountability Act (HIPAA) provides patient protections in connection with the use and disclosure of their health information, in addition to those protections that already exist under state law. Tenet Healthcare Corporation and Brookwood Medical Center (Hospital) are committed to protecting the privacy and security of our patients' health information.

By signing this statement, I acknowledge my responsibility under state and federal law and agree not to disclose or share with others, and keep confidential, any information regarding Hospital patients and proprietary information of Hospital. I agree that if I have access to patient information, not to reveal to any patient specific information, including that this person is a patient at the Hospital and any information I may learn about the circumstances of the patient's care, and further agree not to reveal to anyone else any confidential information of this Hospital. I agree to comply with any patient information privacy and security policies and procedures of the Hospital.

I further acknowledge that the importance of patient privacy, security and confidentiality has also been verbally discussed with me, and that I had an opportunity to ask questions regarding the Hospital's privacy and security policies, procedures and practices.

**I have read and understand the terms of this statement and agree to abide by these terms.** Should I choose to reveal confidential patient information to anyone. I acknowledge that the Hospital provided me with the applicable information and training in order to prevent any and all violations of the laws regarding patient privacy, security and confidentiality.

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guardian if participant is Under 18

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of School Official

\_\_\_\_\_  
Date

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Witness: \_\_\_\_\_