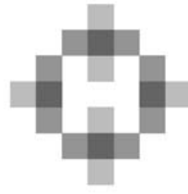

HUTCHINSON
REGIONAL MEDICAL CENTER

PLEASE INITIAL EACH SECTION BELOW

_______**Instructor/Student Validation of Orientation**: I have reviewed the Standardized Orientation and understand how to find **Hutchinson Regional Medical Center** resources should I have additional questions.

______**Confidentiality Agreement**: I understand that I am responsible for complying with the policies of **Hutchinson Regional Medical Center**, including those pertaining to the Health Insurance Portability and Accountability Act (HIPAA). I will treat all information received in the course of my relationship with **Hutchinson Regional**, which relates to the patients, as confidential and privileged information. I will not access patient information unless I have a need to know this information in order to perform my patient care duties or for purposes of education. I will not disclose information regarding patients to any person or organization, other than as necessary to perform my duties, and as permitted under **Hutchinson Regional** HIPAA policies. ***I understand that I shall not remove or copy any health records.*** I understand that some penalties for breaches of confidentiality are subject to certain provisions of state and federal law. I understand that violation of any breach of hospital policies related to confidentiality are a breach of the professional code of ethics, except as it relates to the education process in the classroom or at the practicum site, will result in immediate expulsion from this institution's section of this program.

______**Medical Liability Release**: I acknowledge that as an Instructor/Student with **Hutchinson Regional Medical Center** there exists the potential for sustaining an injury and/or illness. I am aware that in the event of my injury and/or illness, I and/or my own insurance carrier will pay for any medical care cost incurred. I hereby release **Hutchinson Regional** of any necessary health expenses incurred by either illness and/or injury during the period of instruction or observation.

I, ____, have initialed the above sections
(please print your name)
and provide my signature below acknowledging my approval and agreement with the same.

Signature_____________________________________ Date __________

School ____

Nursing Students

Prior to your clinical experience, give this completed form to your nursing faculty. It will be kept on file at Hutchinson Regional Medical Center.

Non-Nursing Students

Prior to your clinical experience give this completed form to the Education department at Hutchinson Regional Medical Center.