Observership Contract

The Federal Health Insurance Portability and Accountability Act (HIPAA) and related laws and regulations were established to preserve the confidentiality of medical and personal information, in addition, to specify that such information may not be accessed, used, disclosed or viewed except as authorized by law or unless authorized by the patient. These privacy laws and regulations apply to all Health System personnel including students and observers. All students / observers are required to agree to and sign this confidentiality statement.

I understand as a clinical observer, I am not permitted to have direct patient contact or to practice medicine. I acknowledge that I do not have medical staff privileges to practice medicine at Ochsner LSU Health. I understand that as an observer, I am not permitted to participate in direct or indirect patient care activities. These restricted activities include but are not limited to hands-on patient care or medical equipment, access to medical information (medical charts, computer work stations, electronic medical record), instruments, medications, infusions, intravenous liquids, lab testing equipment, etc.

I understand that, as an observer for clinical purposes, I may see or hear confidential information, such as medical information about a patient, verbal discussions about patient care, and electronic communications that include confidential patient information.

I acknowledge that it is my responsibility to respect the privacy and confidentiality of patient information and other personally identified information. I will not access, use, or disclose any confidential information outside of my educational experience at Ochsner LSU Health. I will not photograph, videotape or photocopy any patients or patient information.

I understand that if I breach any provision of this Agreement, I may be subject to civil or criminal liability under HIPAA. Failure to abide by these guidelines will result in the immediate termination of the observership.

I understand that I must remain with my sponsor (or his/her designee) while in patient care areas – I am not permitted to move freely around the hospital.

Observer's Name (*Please Print*): _____

Observer's Signature: _____

Date: _____