University Hospitals

Disclosure of Patient/Provider Information

I hereby acknowledge that I am over the age of 18, I am the parent and/or legal guardian of the child ("Student"), and I have the authority to make agreements on behalf of the Student. The student acknowledges and understands the following: that the relationship between University Hospitals ("UH") and its staff with patients, including all services and treatments provided by UH Healthcare Providers ("Staff"), is confidential, and patients provide confidential information about their medical conditions, personal and family affairs to enable the Staff to perform their services; that as a result of their presence, the student may come across information regarding this relationship, including the treatment and services provided by the Staff to the patients and information disclosed by or on behalf of the patients, even if the student is not directly involved in the patient's treatment and services.

Therefore, the student agrees that during and after their student clerkship with UH, they will not disclose any information regarding this relationship, including treatment, patient financial information, services, or any information about the patients, to any person whatsoever. The student will also not allow anyone to examine or make copies of any documents under their possession or control that relate to the patients of the practice.

I understand that it is my responsibility to maintain the confidentiality of this information, and I may not:

- Disclose this information to individuals who do not have a legitimate business or patient care need for it.
- Access information that is not necessary for the performance of my assigned activities.
- Act in a way that would enable third parties without a legitimate business or patient care need to access this information.
- Use this information in a manner inconsistent with my assigned activities.
- Use this information for any purpose other than the purpose for which it was provided to me.

The student acknowledges that the disclosure of such information may cause irreparable harm to the patient or the owner of the information. Therefore, the patient or the owner of the information may seek legal remedies against the student if necessary.

The student also acknowledges that all aspects of and materials related to practice management are the intellectual property of the Staff and are subject to the same rules of patient confidentiality and non-disclosure. The student understands that UH-specific materials must not leave the premises.

Furthermore, the student understands that a breach of this agreement may result in immediate action and the pursuit of appropriate legal remedies in the future.

The student recognizes and acknowledges: that all aspects of University Hospitals (“UH”) and its staff

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Confirmation: BY ACKNOWLEDGING AND SIGNING BELOW, I AM DELIVERING AN ELECTRONIC SIGNATURE THAT WILL HAVE THE SAME EFFECT AS AN ORIGINAL MANUAL PAPER SIGNATURE. THE ELECTRONIC SIGNATURE WILL BE EQUALLY AS BINDING AS AN ORIGINAL MANUAL PAPER SIGNATURE.

Student Full Name: _____ _____

(First Name) (Last Name)

Caregiver/Parent Full Name: _____ _____

(First Name) (Last Name)

Student Signature:_____ _____

Date

Caregiver/Parent Signature:_____ _____

Date