CONSENT FOR PRESENCE OF OBSERVER DURING MEDICAL TREATMENT

I,_____,understand that during any medical consultation, the physicians and staff must devote their full attention to the patient. I therefore agree to:

A. Bring to the attention of the attending doctor & therapist and any medical problems I have which could interfere with the care of the patient. Such problems might include but are not limited to:

- Lapse of consciousness problems, such as fainting, epilepsy, narcolepsy, etc.
- Diabetes
- Claustrophobia
- Weak stomach
- Cough, flu, cold
- Communicable diseases

B. Conform to all ASTR Institute rules and regulations.

C. Comply with all orders and directions of the physicians ASTR staff personal.

D. Leave the area immediately if considered necessary by the physicians or patient.

E. Maintain strict confidentiality regarding all patient care information.

I have been instructed by the physician and staff concerning routine practices utilized during the procedure/ nursing care named on page 2. I hereby release ASTR Institute doctors, staff, officers, directors, agents and employees from any liability in the event of my presence during the procedure results in injury to me, the patient or to others.

OBSERVERS(S) REQUESTING PATIENT CONSENT TO OBSERVE MEDICAL PROCEDURES AND NURSING CARE

Name (Print}:_____Signature:_____ Date:_____

CERTIFICATE OF ATTENDING

I am the attending doctor or therapist of the patient. I have conferred with both the patient and the above named observer(s} and I believe that both understand, and will comply with ASTR Institute policies and procedures regarding the presence of the observer during the medical treatment. It is my medical judgment that the presence of the observer during the medical treatment will not compromise the health, safety or welfare of the patient, the observer or others.

Signature: _____ Date:_____

Print Name: _____(Physical Therapist/ Physical Therapist Assistant}

ASTR Institute Confidentiality Statement for Clinical Observation

The Federal Health Insurance Portability and Accountability Act (HIPAA), the State of California Confidentiality of Medical Information Act and related laws and regulations were established to preserve the confidentiality of medical and personal information, and to specify that such information may not be disclosed except as authorized by law or unless authorized by the patient. These privacy laws and regulations apply to all Health System personnel including students. All students are required to agree to and sign this confidentiality statement. I understand that, as an observer for clinical education 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 this information. I will not access, use, or disclose any confidential information outside of my educational experience at ASTR Institute. I understand that I am required to immediately report any information I may have about the unauthorized access, use, or disclosure of confidential information to the ASTR Privacy Office. I understand that if I breach any provision of this agreement, I may be subject to civil or criminal liability.

Observer's Name/Student's Name (Please Print): _____

Observer's Signature/Student's Signature: _____

Date: _____

(If student is under **18** years of age, then parent/guardian signature is needed as well.) I am the parent/guardian of the student named above and I agree to be responsible for my child's inappropriate access, use, or disclosure of confidential information during his/her participation.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____

Date:_____