



## **Volunteering/Job Shadow Release Form & Confidentiality Agreement**

**The Moore Orthopaedic Clinic, P.A.**

**Please Print**

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

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

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

### **Volunteer Dress Code and Behavior**

It is our desire that your time at our facility is educational and enjoyable. As a volunteer you will be representing the Moore Orthopaedic Clinic through interactions with patients, guests and visitors and are expected to present yourself in a professional manner. We expect all volunteers to wear appropriate clothing such as khakis or jeans without patches or holes, non-revealing shirts, shirts without large logos or inappropriate writing, and no shorts or skirts above the knees. Shirts that show mid drift are not acceptable. For your protection, we also do not allow staff or volunteers to wear open toed shoes. Profanity or inappropriate conversations is also inconsistent with the Moore Orthopaedic Clinic's code of conduct.

### **Medical Information & Release**

**Emergency Contact:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Medication(s)/Allergies/Conditions:** \_\_\_\_\_

I, the undersigned (or parent/guardian), understand the nature of The Moore Orthopaedic Clinic's volunteer program and the activities involved, and state that the individual named on this form is in adequate health to perform, participate or observe the activities carried out in this program. I do ensure and guarantee to hold harmless The Moore



Orthopaedic Clinic, its staff, agents and representatives from any responsibility for liability whatsoever resulting from the individual's actions, activities or injury.

\_\_\_\_\_  
Signature (*Parent/Guardian if under 18*)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Staff Witness

\_\_\_\_\_  
Date

**Confidentiality Agreement**

I, the undersigned, acknowledge that as a result of my association with The Moore Orthopaedic Clinic, may have access to confidential information of the practice, including patient identifiable protected health information. I will hold confidential all patient and practice information obtained and will not disclose any personal, medical related information, or any other confidential information to third parties during and after my time with the Moore Orthopaedic Clinic. Furthermore, I understand that the use and disclosure of patient information is governed by the rules and regulations established under HIPAA (the Health Insurance Portability and Accountability Act of 1996). I am committed to protecting and safeguarding from any oral and written disclosure all confidential patient practice information of which I become aware.

\_\_\_\_\_  
Signature(*Parent/Guardian if under 18*)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Staff Witness

\_\_\_\_\_  
Date