AUTHORIZATION TO RELEASE STUDENT RECORDS

TO: **Emory Healthcare, Inc. Department of Nursing**

RE: _____

(Print Name of Student)

As a condition of my participation in an educational training program and with respect thereto, I hereby waive my privacy rights, including but not limited to, any rights pursuant to the Family Educational Rights and Privacy Act, 20 U.S.C. 1232g(b)(2)(B), and grant my permission and authorize _____ _____(hereinafter referred to as the "Institution") to release any and all of my educational records and information in its possession, including but not limited to, academic record and health information to Emory. I further authorize the release of any information relative to my medical history, physical and mental condition to Emory for purposes of verifying the information provided by me and determining my ability to perform my assignments in the educational training program. I also grant my permission to and authorize Emory to release the above information to the Institution. The purpose of this release and disclosure is to allow Emory and the Institution to exchange information about my medical history and about my performance in an educational training program.

I further agree that this authorization will be valid throughout my educational training program. I further request that you do not disclose any information to any other person or entity without prior written authority from me to do so, unless disclosure is authorized or required by law. I understand that this authorization shall continue in force until revoked by me by providing written notice to the Institution and Emory, except to the extent of any action(s) that has already been taken in accordance with this "Authorization for Release of Records and Information."

In order to protect my privacy rights and interests, other than those specifically released above, I may elect to not have a witness to my signature below. However, if there is no witness to my signature below, I hereby waive and forfeit any right I might have to contest this release on the basis that there is no witness to my signature below. Further, a copy or facsimile of this "Authorization for Release of Records and Information" may be accepted in lieu of the original.

By signing this "Authorization for Release of Records and Information," I hereby indemnify and hold harmless the Institution, its members, agents, servants and employees, and Emory and its members, agents, servants and employees (each of the foregoing being hereinafter referred to individually as the "Indemnified Party") against all claims, demands, causes of action, actions, judgments or other liability including attorney's fees (other than liability solely the fault of the Indemnified Party) arising out of or in connection with this "Authorization for Release of Records and Information."

I have read, or have had read to me, the above statements, and understand them as they apply to me. I hereby certify that I am eighteen (18) years of age or older, suffer under no legal disabilities, and that I have freely and voluntarily signed this "Authorization for Release of Records and Information" as of this the _____ day of _____, 201__.

_____	_____
Signature	Witness Signature
Name:_____	Name:_____
(Please print)	(Please print)

STUDENT AGREEMENT CONCERNING
EDUCATIONAL TRAINING PROGRAM

In consideration for being permitted to participate in a clinical training experience at Emory Facilities listed in Section A.2. of the Affiliation Agreement For Clinical Training Of Nursing Students at Emory Healthcare (individually or collectively referred to herein as Emory"), I hereby agree to the following:

1. To follow the administrative policies, standards and practices of Emory including, but not limited to the following:
    a. Students may administer medications when under the direct supervision of Institution's faculty. Direct supervision is defined as retrieving medications from the medication room through administration of medications at the bedside. This means that 100% of the medication administration process is observed by the Institution's faculty for every medication administered by a student. If for any reason the Institution's faculty is unavailable to supervise the process from the medication room to the patient's bedside, and the medication cannot wait until the Institution's faculty is available, the patient's nurse will administer the medication.
    b. Two licensed RNs will perform the "double-check" for any medications or procedures requiring a "double-check" pursuant to Emory policies and procedures.
2. To report to Emory on time and to follow all established rules and regulations of Emory.
3. To comply with federal and state laws, including but limited to the Health Insurance Portability and Accountability Act of 1996 and its accompanying federal regulations, and the rules and regulations of Emory regarding the confidentiality of all medical, health, financial and social information (including mental health) pertaining to particular clients or patients.
4. To not publish any material related to my educational training program that identifies or uses the name of Emory or its members, clients, students, faculty or staff, directly or indirectly, unless I have received written permission from Emory.
5. To comply with all federal, state and local laws regarding the use, possession, manufacture or distribution of alcohol and controlled substances.
6. To follow Center for Disease Control and Prevention (C.D.C.) Universal Precautions for Blood Borne Pathogens, C.D.C. Guidelines for Tuberculosis Infection Control, and Occupational Safety and Health Administration (O.S.H.A.) Respiratory Protection Standard.
7. To arrange for and be solely responsible for my living accommodations while at Emory.
8. To provide the necessary and appropriate uniforms and supplies required where not provided by Emory.
9. To wear a nametag that clearly identifies me as a student.

I understand and agree that Emory shall not be responsible for any loss, injury or other damage to me or my property arising during my participation in the educational training program.

Further, I understand and agree that I will not receive any monetary compensation from Emory for any services I provide to Emory or its clients, patients or staff as a part of my educational training program.

I also understand and agree that I shall not be deemed to be employed by or an agent or a servant of Emory; that Emory assumes no responsibilities as to me as may be imposed upon an employer under any law, regulation or ordinance; and that I am not entitled to any benefits available to employees. Therefore, I agree not to in any way hold myself out as an employee of Emory.

I understand and agree that I may be immediately withdrawn from the educational training program by Emory based upon a perceived lack of competency on my part, my failure to comply with the rules and

policies of Emory, if I pose a direct threat to the health or safety of others or, for any other reason Emory reasonably believes that it is not in the best interest of Emory or Emory's patients or clients for me to continue.

I understand and agree to show proof of professional liability insurance in amounts satisfactory to Emory, and covering my activities at Emory, and to provide evidence of such insurance upon request of Emory.

I further understand that all medical or health care (emergency or otherwise) that I receive at Emory will be my sole responsibility and expense.

I have read, or have had read to me, the above statements, and understand them as they apply to me. I hereby certify that I am eighteen (18) years of age or older, suffer under no legal disabilities, and that I have freely and voluntarily signed this "Educational Training Program Agreement."

This the ____ day of _____, 201__.

_____ _____

Signature Witness Signature

Name:_____ Name:_____

(Please print) (Please print)