

<b>STUDENT MEDICAL CONFIDENTIALITY STATEMENT</b>
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Student Name \_\_\_\_\_ School \_\_\_\_\_  
Please Print Please Print

Place of Internship: \_\_\_\_\_

To protect individual privacy, information concerning patients, fellow employees, and other medical business are of a confidential nature and must not be discussed with persons not concerned with such information.

As a student intern in the medical field, I agree to the following terms:

1. All medical records are confidential and may not be shared or discussed with anyone unless specifically told to do so by my employer.
2. Information will not be released to anyone without written consent from the patient or family member.
3. I understand that all information concerning patients must be kept where it is accessible to only the office staff.

I understand and agree that in the performance of my duties as an intern at this or any other medical site, I must hold patient, employee, or medical business in confidence. Further, I understand that intentional or involuntary violation of such confidentiality could result in possible civil action, or disciplinary action including termination of my internship.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**GRANITE SCHOOL DISTRICT WORK-BASED LEARNING**

**MEDICAL INTERNSHIP DISCLOSURE**

Students placed in any of the medical areas have the possibility of being exposed to a full view of the human body. The nature of medicine many times requires procedures where a patient may be partially or fully unclothed and in full view of the medical staff including high school medical interns. Medical staff are so used to this that they don't really think about it as anything unusual or as something they would need to hide from our high school medical interns. This is a professional part of medicine and we expect students to handle these experiences in a mature manner. Students will be supervised and monitored at all times during these kinds of experiences.

As a parent we are informing you that if you allow your student to register for a medical internship you accept the above possibilities as part of their internship experience.

I have read the above information and agree to allow \_\_\_\_\_  
(Please print student name)  
to register for a medical internship.

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Date