VISITING OBSERVER ATTESTATION AGREEMENT

As a clinical or administrative visitor to Stanford Health Care (SHC), I will be observing patient care and administrative functions for medical/professional education, training or other purposes. I agree to respect and maintain the confidentiality of all discussions, deliberations, records, and other information to which I have access, and will make no voluntary disclosures of such information except to persons authorized to receive it in the conduct of Medical Staff affairs or SHC business or educational activities.

In addition, I agree to comply with all laws and regulations and will follow the directives of SHC personnel. Furthermore, I understand that no patent right, copyright or other proprietary right of SHC are transferred to me or my agents or assigns. I will not enter into any agreement creating copyright or patent obligations or rights based on my observation during any SHC patient care or administrative/educational activities.

I understand that Stanford Health Care and the Medical Staff(s) are entitled to undertake such action as is deemed appropriate to ensure that the terms of this Attestation agreement is maintained, including application to a court for injunctive or other relief in the event of a threatened breach of this agreement.

The obligations set forth in this Attestation shall survive the term of my time at SHC or any type of involvement with patient care or administrative activities.

I certify the following:

☐ I will be observing for training purposes OR ☐ Other purpose: __________________________

   NOTE: patient authorization is required for observations unrelated to training.

☐ I will not take any photographs of patients/procedures or videotape my observations.

☐ I have reviewed SHC’s Code of Conduct.

☐ I have reviewed SHC’s HIPAA Guidelines or I have completed HIPAA training at my current place of employment or external sponsoring entity.

☐ I do not have a cold, fever, or communicable disease that would pose a risk to others.

I have read, understand, and agree to abide by the above statements.

____________________________     ____________________________   ___________
Visiting Observer’s Name                         Signature                             Date
(Please print legibly)

__________________________________________________________    ______________
Company/Organization                        Duration of Visit

NPM 1.73
I agree to supervise and accompany the Observer identified above. If the observation is not for training purposes I agree to obtain written HIPAA patient authorization for each patient observed.

Host’s Name (Please print legibly)  Department  Date

___________________________________
Signature

___________________________________
Telephone No.  Pager No.

APPROVED:____________________________
Clinical Department Head or Service Chief for Host

The completed form should be taken to Security-Photo ID, 300 Pasteur Drive, H0258C or faxed to 650/736-1395.