MIDTOWN
222 NW 12TH STREET,
OKLAHOMA CITY, OK 73103
405.232.8631

VOLUNTEER CONFIDENTIALITY ACKNOWLEDGEMENT AND AGREEMENT FORM

During the course of your volunteer activity, you may have access to information which is confidential. It may not be disclosed except as permitted or required by law and in accord with Crossings Community Clinic policies and procedures. In order for the Clinic to properly care for patients and engage in successful business planning, certain information must remain confidential. Improper disclosure of confidential information may cause irreparable damage to the Clinic. Confidential information includes, but is not limited to:

1. Medical and certain other personal information about patients.
2. Medical and certain other personal information about employees.
3. Medical staff records.
4. Reports, policies and procedures, marketing or financial information.

By signing this Confidentiality Acknowledgment, I acknowledge and agree that:

1. I will only access business information for which I have a legitimate business purpose as approved by a duly authorized representative of the Clinic.
2. I am obligated to and will hold confidential information in the strictest confidence and will not disclose the information to any person or in any manner which is inconsistent with this agreement.
3. I will print information only when necessary for a legitimate purpose and when approved by a duty authorized representative of the Clinic. I am accountable for this information until it is destroyed.

I HAVE READ AND UNDERSTAND THIS CONFIDENTIALITY AGREEMENT.

Volunteer Signature: ____ Date: _______________

Print Name: ____

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CROSSINGS COMMUNITY CLNIC WAIVER and RELEASE of LIABILITY

This Waiver and Release of Liability ("Agreement") is a legal and binding agreement which, when signed, will permanently limit your ability to hold the Crossings Community Clinic liable for injuries or losses you may cause or sustain as a result of your decision to perform, without compensation volunteer tasks ("Services") for the the Clinic.

Volunteers performing Services regardless of the location of the Services and regardless of whether the Volunteer is identified as being associated with the the Clinic, the Volunteer must complete and sign this Waiver and Release of Liability prior to beginning their voluntary service with the Clinic.

The Crossings Community Clinic is a private institution. I am a current or prospective Volunteer at

the Clinic performing Services in the ____. (Department)

I *(print your name)* ____ freely choose to act as a Volunteer and not a Clinic employee and perform the following Services which include the following physical or mental activities such as walking, standing, sitting, bending, lifting, reading, speaking, hearing, etc.

I agree to inform myself about the potential dangers of the Services and any precautions I should take and any information that the Clinic may provide.

Despite precautions, accidents and injuries can and will occur. I understand that the Services may be dangerous and that I may be injured and/or lose or damage personal property as a result of performing the Services. Should there be a needle stick involved in the care of our patients, the needle stick protocol will be initiated.

I FULLY AND COMPLETELY ASSUME ALL RISKS RELATED TO THE ACTIVITY including death, injury, illness, or loss from accidents, theft of or damage to personal belongings. **All costs for follow up care will be borne by the volunteer.**

I agree with the above terms and conditions of Release of Liability.

Signature of Applicant: _______________________________________ Date: ______________

Volunteer Coordinator: _______________________________________ Date: ______________