

**Lane Community College**  
**Physical Therapist Assistant Program 2012-13**

***Consent and Acknowledgement Form***

**Privacy and Confidentiality**

Patient/client and student information from any source and in any form (such as written, verbal or computer-generated) is confidential and will be used for educational-only purposes.

I shall protect the privacy and confidentiality of students and patient/client information. Access to this information is allowed only if I need to know it to fulfill my responsibilities as student in the classroom and/or in the clinical facility.

In my position, I may see or hear confidential information concerning, patients/clients or family members. Such sources of information include medical/dental records, financial applications, abuse reports, radiographic requests, medical test results, patient/client records and conversations.

I will comply with program and college policies regarding confidential verification of my identity while enrolled in courses offered through distance learning.

I agree to the following:

1. I will access only that information needed to fulfill my course work and clinical education responsibilities.
2. I will not tell, show, copy, give, sell, review, change or dispose of any confidential information unless it is part of my course work or clinical education responsibilities. If it is a part of my responsibilities to do these tasks, I will follow the correct procedures.
3. I will consider that conversations between the physical therapists, physical therapist assistants and health care workers or between the undersigned and a patient/client are also protected and may not be discussed.
4. I will, under no circumstance, discuss the medical condition, including HIV or infectious disease status, of any patient/client where the conversation may be overheard by any other patient/client or by other students, faculty and clinical facility personnel.
5. I will not misuse or be careless with confidential information.
6. I will not share any confidential information if I am no longer a Lane Community College Physical Therapist Assistant program student.
7. I will protect the privacy of patients/clients, students and employees.
8. I am responsible for the use and misuse of confidential information.
9. I am responsible for timely communication of barriers to full participation in classroom and clinical activities.

Failure to comply with Lane Community College and Physical Therapist Assistant Program policies regarding privacy and confidentiality may result in dismissal from the program.

## **Informed Consent**

1. I understand the Disclosure to Students in the Program Policy Manual and acknowledge Candidacy is not accreditation status nor does it assure eventual accreditation.
2. I understand that I am expected to participate in classroom, laboratory and clinical activities in order to demonstrate achievement of course objectives.
3. I understand the instructor(s) may ask me to participate in classroom and clinical demonstration of hands-on techniques.
4. I understand that I will participate in hands-on simulated practice with classmates.
5. I am responsible for identifying and communicating any barriers to fully participating in classroom, laboratory and clinical activities and will seek reasonable accommodations to meet course objectives.
6. I understand that refusal to participate may effect my ability to meet minimum achievement of course learning objectives, and therefore, result in dismissal from the program.
7. I understand I am responsible for following lab use policies and assume full responsibility for my safety when electing to use the lab for unsupervised practice.
8. I understand I assume responsibility for costs associated with verifying my identity during proctored testing when enrolled in courses offered through distance learning.
9. I will identify myself as a student when participating in community or clinical learning activities.
10. I will respect a patient's right to refuse, without prejudice, supervised treatment from a student.
11. I understand that I need advanced permission to record, publish, and or post information about students and non-students who participate in the program.
12. I understand any audio, video, print, or other imaging information of students and non-students who participate in the program are for instruction-only purposes.
13. I understand that completing the clinical education requirement may require, and be dependent on results of, drug testing and criminal background checks.
14. I authorize the release of personal and/or instructional information for reference(s) to other educational programs, cooperative education facilities, and to prospective employers.

By signing this, I agree that I have read, understand and will comply with program privacy, confidentiality, and informed consent policies and procedures.

Student Signature\_\_\_\_\_

Date\_\_\_\_\_