ReGenesis Health Care
My Family. My Doctor. My Choice.

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Observation ("Shadowing") Consent and Release Form

In consideration of the opportunity to observe the performance of medical personnel at ReGenesis Health Care ("shadow") as part of an observation/shadow program, I agree to the following:

- I understand that patients undergoing examination, procedure or treatment must consent to my presence.
- I agree to maintain and protect the absolute confidentiality of the names of the patients and any other patient identifying information, as well as all information relating to the condition, diagnosis, and treatment of any patient of which he/she becomes aware during observation.
- I understand that this is an observation only experience. I agree not to provide care of any kind to any patient or to document in any patient's electronic medical record.
- I understand that ReGenesis Health Care will not assume or provide any type of insurance coverage, including malpractice insurance coverage, for me while I am shadowing at ReGenesis Health Care.
- I will always wear a ReGenesis Health Care Student Observer identification badge while in RHC medical offices and clinical areas identifying me as a student observer. I will surrender the badge to the Human Resources Department when the experience is completed.
- I understand that I will, always, remain in the presence of the Provider whom I am shadowing. I will leave the patient care areas when the shadowing Provider leaves.
- I acknowledge that no assurance or representation concerning my health or safety during the period of my observation have been made to me. I understand that numerous risks to health and safety may be present in a medical office and clinical space, including but not limited to exposure to infectious agents, and I voluntarily assume all risks associated with my presence in RHC's clinical area as an observer.
- I understand that ReGenesis Health Care reserves the right to terminate the observation experience at any time.

I hereby release ReGenesis Health Care, its medical staff, providers, directors, officers, employees, agents and representatives from any liability, injury or damages caused by or arising from or in connection with my presence as an observer in RHC's clinical areas.

_____
Student Observer's Name (Print)

_____
Shadowing Provider's Name (Print)

_____
Student Observer's Signature

_____
Shadowing Provider's Signature

_____
HR Approval Signature & Date

_____
Chief Medical Officer Signature