As a participant in clinical rotations at the Hospital, I hereby acknowledge my responsibility to keep all patient and business information of the Hospital and HealthSouth confidential, in accordance with federal and state laws and regulations and the Agreement made by and between the Hospital and School. Furthermore, I agree, under penalty of law, not to disclose:

(i) specific information regarding any patient to any person or persons, except to authorized clinical staff and associated personnel as necessary to perform my clinical rotation duties;

and

(ii) any confidential business information of the Hospital and HealthSouth to any third party. This Statement of Confidentiality shall continue in effect after my clinical rotation at the Hospital has expired or terminated.

Dated this ____ day of ______________, 20__. 

______________________________
Name of Student (Print) 

______________________________
Signature of Student
By signing below, I hereby acknowledge that I have received a copy of HealthSouth's Drug and Alcohol Policy and agree that I will read the policy.

I understand that situations may occur in which I will be required to take a drug or alcohol test or submit to a search of my person or possessions in accordance with Hospital policy. I also understand that I may be withdrawn from participation in my clinical rotation at the Hospital: (i) by refusing to take a drug or alcohol test; (ii) by refusing to allow a search; (iii) if a drug or alcohol test proves positive; or (iv) if a search discloses possession of a prohibited item, such as a weapon.

I further understand if I am involved in a work-related accident, I may be required to submit to a blood or urine test. I also understand that I may be withdrawn from participation in my clinical rotation at the Hospital: (i) by refusing to take a blood or urine test; or (ii) if such blood or urine test proves positive.

I also understand that upon my request I will be provided a list of all drugs/substances for which tests will be conducted.

I further understand that adherence to HealthSouth's Drug and Alcohol Policy is a condition of clinical rotation for all students and hereby consent to and accept such policy as a condition of my rotation.

______________________________  __________________________
Student Signature                      Date

______________________________
Student Printed Name
EXHIBIT C
RELEASE STATEMENT CERTIFICATION

I hereby authorize HealthSouth Corporation and/or its agents to make an independent investigation of my background for the purpose of confirming the information contained on my application and/or obtaining other information which may be material to my qualification for employment or participation in a clinical rotation within a Healthsouth hospital, and to conduct pre-employment or other employment related inquiries after I am hired or selected to participate in a clinical rotation at a Healthsouth Hospital (to the extent allowed by law). This investigation may access records maintained by both public and private organizations. Information requested may include, but is not limited to:

- Professional and personal references
- Motor vehicle records
- Criminal and police records
- Public records
- Education
- Past and current employment
- Professional credentials
- Urine or blood tests to determine drug or alcohol use.

I authorize any individuals or entities contacted during this investigation to give you any and all pertinent information they may have, personal or otherwise, and release all parties from any and all liabilities, claims or law suits in regard to the information obtained.

I understand that the complete and final results of HealthSouth’s investigation of my background may not be available to HealthSouth before employment, if any, with the Company commences. I also understand that the results of HealthSouth’s investigation into my background may affect my employability, continuing employability or eligibility to participate in a clinical rotation within a Healthsouth hospital.

The following is my true and complete legal name and all information is true and correct to the best of my knowledge.

Signed: __________________________ Date: ______________

(Applicant)

PLEASE PRINT THE FOLLOWING INFORMATION. FILL IN ALL BLANKS COMPLETELY:

Last Name: ____________________ First Name: ___________________ Middle Name: ___________

Other names you have used in the past 5 years. (Maiden name, nickname, alias, etc.): __________________

Present Address: ________________________________________________

Previous: ______________________________________________________

Provide the following information on places you have worked or lived during the past five years:

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>From: Month/Year</th>
<th>To: Month/Year</th>
<th>City</th>
<th>State</th>
<th>From: Month/Year</th>
<th>To: Month/Year</th>
</tr>
</thead>
</table>

Driver’s License #: __________________________ State of License: __________ Date of Birth: __________

Social Security Number: __________________________ Position Applying For: __________________________

If an investigative consumer report is pulled on me for employment purposes, I wish to receive a copy of the report from TransUnion Birmingham Division.

* Date of birth is used only for purposes of record identification when requesting the above mentioned reports.

FOR FACILITY USE ONLY

**The following information must be completed by the Hospital in order to process this request. Please PRINT clearly**

Hospital Name: __________________________ Hospital Number: __________

Requested By: __________________________ Secured Fax Number: __________

Job Title: __________________________ E-mail address: __________________________

(Must be Supervisor or above)

○ Criminal (Required for affiliation students on site for longer than two weeks.) Result: __________ Date: __________ Source: __________

Hospital Use ONLY: Fax form to: 205-802-7896 To obtain results call: 1-800-417-4669 or check your e-mail address.
Confidentiality and Privacy mean that the patients have the right to control who will see their protected health information. With the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a patient's right to have his/her health information kept private, secure and confidential became more than just an ethical obligation of healthcare providers; it became a federal law.

Protected Health Information (PHI) includes patient identity, address, age, social security number and any other personal information that patients are asked to provide. In addition, protected health information includes why a person is sick or in the Hospital, what treatments and medications he/she may receive, and other observations about his/her condition or past health conditions.

Healthcare providers use information about patients to determine what services they should receive. Ask yourself before looking at any protected health information:

- Do I need this in order to perform my clinical rotation duties and provide quality care?
- What is the least amount of information I need to perform my clinical rotation duties?

Depending on your task, if you do not need to know confidential patient information, then you should not have access to it.

Ways to protect a patient's privacy include:

- Keep discussions about patient care private if reasonably possible by closing doors, pulling curtains and conducting discussions so that others cannot overhear.
- Keep medical records locked and out of public areas.
- If you find that you are overhearing someone else discuss patient information, let them know they can be overheard. And politely remind the individual of the Hospital's privacy policies.
- Do not release any patient information, unless your supervisor has obtained a written authorization from the patient.
- Do not leave messages on answering machines regarding a patient's condition or test results.
- If you should need to copy medical records to complete an assignment, ask your supervisor for permission before making copies. Redact the patient's personal identifiers (i.e. name, date of birth, address, medical record number, insurance information and social security number, if captured) prior to taking the record out of the hospital. Return all copies to the hospital and shred.
- If there are persistent problems regarding breaches of confidentiality or you have any questions, notify or contact your clinical rotation supervisor at the Hospital.

As a student participating in a clinical rotation at the Hospital, I recognize the patients' right to privacy and agree to abide by the Patient's Bill of Rights as posted within the Hospital.

Additionally, I agree that information relating to a patient's physical and/or emotional status will not be released or discussed except as needed for the care of that patient.

I also understand that breaking HIPAA's rules and regulations can mean either a civil or criminal sanction (penalty).

My signature below indicates that I have read and understood the above information, and will abide by the policies and procedures of the Hospital.

Date

Student Signature

Student Name

Employee Signature

Employee Name

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