CONFIDENTIALITY STATEMENT

I understand and agree that, in the performance of my duties as a Teen Volunteer of Henry Medical Center, I must hold patient/medical information in confidence. Information should not be discussed with any individuals including co-workers, other volunteers, students, or family.

I also understand that any violation of patient confidentiality may result in termination from the Teen Volunteer Program.

APPLICANT'S SIGNATURE:___________________________________**DATE**:_________________

PERMISSION OF PARENT OR GUARDIAN FOR TEEN VOLUNTEER TO SERVE WITH THE HENRY MEDICAL CENTER AUXILIARY

APPLICANT'S AND PARENT'S STATEMENT (Please read carefully before signing)

I hereby certify that all information given on this application is true and correct to the best of my knowledge.
I hereby give my permission for my son/daughter to join the Henry Medical Center Auxiliary's Teen Volunteer Program and if chosen to attend the necessary orientation for the program. I also give my permission for him/her to render the minimum six weeks of service required of the Teen Volunteer. I also give permission to Henry Medical Center to print my teen's photo/name in the local area newspapers as a member of the Teen program. I also understand that my teen must keep all patient and medical information confidential or else they may be terminated from the program.

____

Signature of Parent/Guardian Relationship Date

This form must be completely signed and returned by the February 1st deadline will all other required documents in order to be considered for the summer program.

MAILING ADDRESS:

Henry Medical Center Teen Auxiliary
Volunteer Services Department
1133 Eagle's Landing Parkway
Stockbridge, GA 30281
Office # 678 604 1057
Fax # 678 604 5060