2107 Fauquier Health Junior Volunteer Program

Please mail the original signed document to –
Fauquier Health Volunteer Services
253 Veterans Drive
Warrenton, VA 20186
This document must be received by March 31, 2017

Student name (please print) _______________________ Phone number _____________________

Parent / Guardian Consent:

_______________________ (Applicant) has my consent to participate in the Junior Volunteer Program at Fauquier Health.

Signature of Applicant's Parent / Guardian ___________________________ Date _______________

Photo Consent:

I hereby give my consent to have photographs, videotaped images, and other images made of me, or my son or daughter, who is participating in the Fauquier Health Junior Program and / or consent to interviews with a member of the news media or a representative of Fauquier Health about the program. I understand and agree that these images many be used by the news media or by Fauquier Health to publicize the programs.

Signature of Student ____ Date __________________

Signature of Parent / Guardian ___________________________________ Date ___________________

Confidentiality Agreement:

As a Junior Volunteer at Fauquier Health you may have access or become aware of information of a confidential nature. A major part of confidentiality relates to Protected Health Information (the medical condition and treatment of patients, including employees who use our facilities as patients). Other areas of confidentiality may include specific methods by which the hospital does business, marketing strategies, compensation of employees, names of patients*, names of potential financial benefactors, negotiating tactics, and employee evaluations.

I recognize that I have a duty of loyalty to Fauquier Health and its patients and should I violate this duty be releasing confidential information, the hospital and its patients may be harmed. I agree to keep such information confidential and understand that any failure on my part to so many result in disciplinary action up to and including termination of volunteer services.

*in situations where the patient has not authorized release of his or her name in accordance with HIPPA privacy rules and regulations and in situations where the disclosure is being made to competitors or potential competitors.

Signature of Student ____ Date _______________