

CONTINENTAL NURSES

(888) 894-2900 (phone)

(888) 894-2073 (fax)

Confidentiality Agreement for Agency Healthcare Providers As required by Participating Institutions

While performing services pursuant to The New Mexico Travel Registry Program Agreement between my employer ("Agency") Continental Nurses and the Participating Institution ("Institution"), I hereby agree to the following provisions:

Medical Records Confidentiality: I understand that while performing services under this Agreement, I might have access to records relating to the treatment of patients of Participating Institution ("Medical Records"). I hereby agree not to disclose any Medical Records or the contents of any Medical Records except in accordance with the Health Insurance Portability and Accountability Act to anyone other than (i) any employee of Participating Institution who needs to know the contents of the Medical Records in the performance of their employment; and (ii) members of the Participating Institution Medical Staff involved in the direct care of the concerned patient. To the extent that the Medical Records relate in any way to the treatment of alcohol or drug abuse, I acknowledge (i) that I am bound by regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. 2.1 et seq. and (ii) if necessary, I will resist in judicial proceedings any efforts to obtain access to the Medical Records, except as provided in the above-cited regulations. To the extent that the Medical Records contain test results governed by the Human Immunodeficiency Virus Test Act, Participating Institution makes the following disclosure to me regarding such records:

"This information has been disclosed to you from records whose confidentiality is protected by State Law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains or as otherwise permitted by State law. A person who makes an unauthorized disclosure of this information is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed six months or the payment of a fine of not more than five hundred dollars (\$500.00), or both."

Non-Discrimination: In performing services under the this Agreement, I understand that I and the Participating Institution will make services available for the sick of the area served without regard to race, color, religion, national origin, age, sex, sexual preference, ancestry, or handicap, and will not discriminate in any manner whatsoever.

Compliance with Institution Policies and Applicable Law: In discharging duties under this Agreement between Institution and my employer, I agree to comply with any Rules and Regulations, Institution policies and procedures, standards and requirements of the Joint Commission on the Accreditation of Health Care Organizations, Medicare, Medicaid, and other licensing and accrediting agencies, and all applicable federal and state statutes and regulations.

Limitation on Liability: While performing services under this Agreement, I understand that Institution will not be liable to any Agency Healthcare Provider, nor to any person making claim on behalf of such Agency Healthcare Provider, for any injury, death or damage to the person or property of such Agency Healthcare Provider, arising from any cause whatsoever during the provider's scheduled assignment at Institution when Agency Healthcare Provider is participating in an assignment in connection with the Agreement executed between Institution and the Agency Healthcare Provider's employer; unless injury, death or damage to the person or property is caused by the negligent acts of Institution, its directors, or employees.

Exposure to Blood or Body Fluids: While performing services at Institution, I understand that it will be my responsibility to report any exposures to blood or body fluids to a representative of Institution as well as to my Agency employer's designated representative, and to follow the exposure control plan which has been developed and adopted by Institution, to be applied in conjunction with the exposure control plan which has been developed and adopted by my Agency employer.

Illness or Injury: I understand that it is my responsibility to become familiar with and to comply with the particular policies of my Agency employer related to illness or injury while on the Institution's premises, including reporting of illness or injury and procedures to be followed. If I am unfamiliar with any policies or procedures in regard to illness or injury, I agree to ask my Agency employer for clarification as soon as possible.

Supervision: While performing services under this Agreement, I understand that I will be working under the supervision of Institution personnel. In addition, I understand that I am not to initiate any patient care activities for which I do not feel qualified and/or do not have recent experience in performing, and agree to discuss as may be necessary with personnel assigned to supervise my performance.

By: _____ Date: _____
Signature of Agency Employee

Witnessed by: _____ Date: _____

Agency: Continental Nurses Dates of Service: _____

Agency Healthcare Provider Information

The following information is requested to assist the Institution in case the need should ever arise to locate you. This information will be held in strict confidence.

Name: _____ Maiden Name (if applicable): _____
Current Address: _____
Permanent Address: _____
Phone number: _____
Past Address: _____
Professional License Number (s)/State (s): _____

Please list below the names, addresses, and telephone numbers of your two closest living relatives with whom you do **not** live:

_____	_____
_____	_____
_____	_____
Phone: _____	Phone: _____