**Cleveland Clinic**
VOLUNTEER SERVICES DEPARTMENT

# *ASSOCIATE AMBASSADOR*

## APPLICATION

**NAME:** _____
(Last) (First) (Middle)

**ADDRESS:** _____
(Street)

_____
(City) (State) (ZIP)

**TELEPHONE:** (H)_____ (W)_____ (Cell)_____

**E-MAIL:** _____ **BIRTHDATE:** (Month/Day)_____

**EMERGENCY CONTACT:** _____

**RELATIONSHIP:** _____ **PHONE:** _____

**CLEVELAND CLINIC EMPLOYEE?** ☐ **YES** ☐ **NO** **DEPT.**_____

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***Please indicate below which Associate Ambassador group you are affiliated with.***

- ☒ ***Cleveland Clinic Concert Band***
- ☐ ***Crafts Committee***
- ☐ ***Sewing Circle***
- ☐ ***Knitting Volunteers***
- ☐ ***Other*** _____

**SIGNATURE:** _____ **DATE:** _____

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# PHOTO RELEASE FORM

Cleveland Clinic Health System is committed to educating the public and other healthcare providers about medical treatments and innovations. One of the most effective ways to share news is through personalized stories. Thank you for agreeing to participate in these educational efforts. This form ensures that you understand how your information will be used and that you agree to its release.

The information that will be released is:
*Photographs and other general information*

News media or other organizations to which the information may be released:
*Local newspapers, internet and intranet (CC web page), Ambassador Newsletter, brochures, radio and television programs, and other general sources.*

I understand that news media organizations are not covered by federal privacy regulations and that the information described above, once released, may become available for use by the media at any time in the future.

I understand that any photograph, movie, video or audiotape taken will become and remain the sole property of Cleveland Clinic Health System or of the authorized media organization named above. I agree that the interview, negatives, prints, videotapes, audiotapes or computer graphics prepared there from may be used for any purpose, including brochures, newspapers, magazines, Web sites, television, billboards, exhibits, audiovisual or multimedia presentations, kiosk imaging, radio broadcasts, and any other news, public service, promotional or advertisement reason.

Volunteer Name (Please Print) Signature Date

Street Address

City State Postal/ZIP Code

Telephone Number Date of Birth

Parent/Guardian Name (Minors Only) (Please Print) Signature Date

Volunteer Services Department Representative (Please Print) Signature Date

This authorization will not expire.

Rev. 1/13/09

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# CONFIDENTIALITY AGREEMENT

During the course of volunteering/observing at Cleveland Clinic (CC), you may have access to confidential information concerning CC's business, finances, patients and employees. This information may be in the form of verbal, written and/or computerized data. You must refrain from discussing or giving out any information regarding a patient's reason for treatment, diagnosis, condition, test results or family or personal affairs unless it relates to the performance of your duties. The protection of this confidential information is a critical responsibility of each employee and volunteer, and your willingness and ability to treat any such confidential information in this manner is a prerequisite to your ability to participate as a volunteer.

Under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Protected Health Information (PHI) is any information that is created, received and maintained by CC related to an individual's health care (or payment related to healthcare) that directly or indirectly identifies the individual. Use of PHI refers to the sharing, applying or analyzing of PHI within CC. "Disclosure" refers to the release of PHI outside CC.

The use and disclosure of PHI by CC employees/volunteers shall occur only in accordance with HIPAA Privacy Policies. PHI may be accessed only by those individuals who, within the scope of their volunteer duties, have a legitimate need for such information for purposes of patient care, research, education or administrative uses. Any other use or disclosure of PHI may be considered a major infraction of CC policy, and may be subject to criminal penalties.

Access to confidential information contained or generated by the computer system will be restricted to those who need this information to carry out their volunteer duties. Further, the taking of photographs or any other electronic or recorded images, videotaping, audiotaping, electronic or data recording by any mechanisms including but not limited to cameras, video cameras, movie cameras, cell phones or cell phone cameras, personal digital assistants or any recording device without the express written consent of the individual is strictly prohibited. (Audiotaping of employees may occur in designated areas for purposes of quality control.) CC shall document sanctions that are applied against volunteers and members of its workforce. A summary of the documentation will be forwarded to the CC Privacy Officer. Only physicians or designated individuals may release information to the media or other inquiring sources.

The acquisition, release, discussion or other use of confidential information for purposes other than to conduct normal authorized business activities is strictly prohibited. Violation of confidentiality is a very sensitive matter and grounds for termination as a volunteer.

Questions regarding interpretation of this policy related to business and patient information should be directed to the Director of Volunteer Services, Privacy Office and Office of General Counsel. Questions regarding employment-related information should be directed to the Chief Human Resources Officer.

I understand my obligation to maintain confidentiality as well as the consequence for failure to do so.

| Print Name | Signature | Date |
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