

RELEASE OF LIABILITY AND CONFIDENTIALITY AGREEMENT

To be executed by visitors to the Dental Clinics at the University of Louisville School of Dentistry

Name: _____

Date(s) of visit: 09/01/24 - 09/01/25 Purpose of Visit: _____

I request that the University of Louisville School of Dentistry (ULSD) grant me permission to observe activities of and/or tour the Dental Clinics on the date(s) listed above. In consideration the University granting me this permission, I release the University from any liability to me for any injury I might sustain as a result of my participation from any cause whatsoever, except for willful and deliberate behavior on the part of the University or one of its employees acting within the scope of that employee's duties.

I understand that my involvement will be limited to observation and/or tour only, and I will not be allowed to participate in patient treatment. I further understand that there are certain risks incident to my presence in the Dental Clinics, including exposure to infectious diseases and other unfavorable adverse incidents, and I certify that I fully accept these risks and release the University for any claims for damage or bodily injury that I might suffer as a result of exposure to these risks.

All of my activities will be in accordance with Kentucky Board of Dentistry Regulations and in accordance with all applicable University policies that affect University visitors generally.

Confidentiality - I understand and agree that ULSD has legal and ethical responsibilities to protect the privacy and security of all patients and to protect the confidentiality of its patients' protected health information. I understand I am expected to comply with ULSD policies as related to maintaining the privacy and security of patients' individually identifiable health information.

- I know it is my right and responsibility to seek guidance about privacy and security issues when I am uncertain about which actions to take.

- I will fully cooperate in any investigation of conduct, which may be a violation of ULSD's policies/standards.

I also agree to the following statements:

- I will not disclose or discuss any Confidential Information with others.

- I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.

- I will not discuss Confidential Information where others can overhear the conversation.

- I understand it is not acceptable to discuss Confidential Information even if the patient's name is not used.

- I will not make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information.

- I agree that my obligations under this Agreement will continue after my relationship ceases with ULSD.

My signature below indicates I agree to the contents of this Agreement and Release.

Visitor

Date