



**Presbyterian Healthcare  
Request for Observation Only Privileges**

Date(s) of Proposed Visit	
Sponsoring Physician (name of current medical staff member you will be observing)	
Brief description of the nature and purpose of the visit	
<b><i>Applicant Acknowledgement &amp; Agreement:</i></b>	
<p>I am currently licensed as a physician or mid-level provider and have enclosed a copy of my current license/certificate. I agree that as a condition of being permitted to Observe Only at the above requested facility(ies) of Presbyterian Healthcare System, I</p> <ul style="list-style-type: none"> <li>➤ Shall not, under any circumstances, diagnoses, or attempt to diagnose, treat or attempt to treat, operate or attempt to operate on, or prescribe for or administer to, or profess to treat any patient of the above facilities or otherwise engage in the practice of medicine or surgery as defined by N.C. General Statute § 90-18;</li> <li>➤ Shall abide by the rules, policies and procedures established by Presbyterian Healthcare System including, without limitation, any administrative direction and instruction which may be provided from time to time, and those various governmental or accrediting agencies applicable to Presbyterian Healthcare System.</li> <li>➤ Shall obtain from the Medical Staff Services Department and display at all times, an Observer identification badge; and</li> </ul> <p>I release Presbyterian Healthcare System and Novant Healthcare and its subsidiaries, successors, assigns, officers, supervisors, agents and representatives from any and all claims and demands of every nature which Visiting Physician or Mid-level Provider may have or assert growing out of or pertaining to his/her visit to the facility.</p>	
Signature of Visiting Physician/Mid-level Provider	Signature Date
<p>As a sponsoring physician/dentist, I certify that the Visiting Physician/Mid-level Provider is to be engaged solely for the purpose of observation, and that no element of direct patient care will be provided by the Visiting Physician and/or Mid-level Provider.</p>	
Signature of Sponsoring Physician	Signature Date



**Confidentiality Agreement**

In consideration of being granted observation privileges at a Novant Health, Inc. ("Novant") facility, I agree that:

**PROPER USE AND/OR DISCLOSURE OF CONFIDENTIAL INFORMATION**

1. I will use and/or disclose **protected health information (PHI)** or other confidential information only for the purposes of treatment, payment, or health care operations, or as otherwise required by law. I will not use or disclose **PHI** or other confidential information other than as permitted by this agreement or as allowed by law. I will not attempt to access information that I am not authorized and required to access to perform my duties.
  - a. I will avoid discussions about specific patients with or around those who are not directly involved in the patient's care.
  - b. I will refer all media requests for information to Novant's Marketing and Communications department. I will refer all other outside requests for information to Novant's Administrator on Call.
2. I understand that non-public information regarding business contracts and/or other business relationships between a Novant entity and others also may be confidential.

***MEASURES TO PROTECT CONFIDENTIAL INFORMATION***

3. I will use all appropriate measures to maintain the security of **PHI** and other confidential information and to prevent unauthorized use and/or disclosure of this information.
  - a. I will not leave confidential printed, written or electronic information visible in areas accessible by unauthorized individuals except in emergencies.
  - b. If I am granted a computer sign-on code, identification badge and/or a remote security access device, then I agree to comply with Novant's policies and procedures regarding use of same.

**REPORT OF IMPROPER USE AND/OR DISCLOSURE**

4. I will immediately report in writing to the designated Privacy Officer of Novant any use or disclosure of **PHI** that is not permitted by law within 14 days of my discovery of this unauthorized use and/ or disclosure.

**TERMINATION AND PENALTIES**

5. I understand that if I violate Novant's confidentiality policies or this agreement that I am subject to discipline in accordance with the applicable facility's Medical/Dental Staff Bylaws and Rules and Regulations, and/or legal action, including criminal prosecution.
6. I hold Novant harmless from any legal liability for the actions I commit that violate Novant's confidentiality policies or this agreement.
7. I have been advised regarding Novant's confidentiality policies. I have reviewed this agreement.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date