UNIVERSITY OF CALIFORNIA, San Francisco

Waiver of Liability, Assumption of Risk, and Indemnity Agreement

Waiver: In return for being permitted to participate in the following activity or program ("The Activity"), including any associated use of the premises, facilities, staff, equipment, transportation, and services of the University, I, for myself, heirs, personal representatives, and assigns, **do hereby release, waive, discharge, and promise not to sue** The Regents of the University of California, its directors, officers, employees, and agents ("The University"), from liability **from any and all claims, including the negligence of The University**, resulting in personal injury (including death), accidents or illnesses, and property loss, in connection with my participation in the Activity and any use of University premises and facilities.

Description of Activity or Program: SCORE: Students Capturing the Operating Room Experience

Date(s): April 19, 2024

Assumption of Risks: Participation in The Activity carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injury. The specific risks vary from one activity to another, but the risks range from 1) minor injuries such as scratches, bruises, and sprains, to 2) major injuries such as eye injury, joint or bone injuries, heart attacks, and concussions, to 3) catastrophic injuries such as paralysis and death.

Indemnification and Hold Harmless: I also agree to indemnify and hold The University harmless from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees, arising out of my involvement in The Activity, and to reimburse it for any such expenses incurred.

Severability: I further agree that this Waiver of Liability, Assumption of Risk, and Indemnity Agreement is intended to be as broad and inclusive as permitted by law, and that if any portion is held invalid the remaining portions will continue to have full legal force and effect.

Governing Law and Jurisdiction: This Agreement shall be governed by the laws of the State of California, and any disputes arising out of or in connection with this Agreement shall be under the exclusive jurisdiction of the Courts of the State of California.

Acknowledgment of Understanding: I have read this Waiver of Liability, Assumption of Risk, and Indemnity Agreement, fully understand its terms, and **understand that I am giving up substantial rights, including my right to sue.** I confirm that I am signing the agreement freely and voluntarily, and **intend my signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law.

_____ _____
Participant Name (print) Date of Birth

_____ _____
Participant Signature Date

I, the parent/legal guardian of the Participant, hereby agree to the above on behalf of the Participant.

_____ _____ _____
Parent/Guardian Name (print) Signature Date

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO CONFIDENTIALITY OF PATIENT, EMPLOYEE AND UNIVERSITY BUSINESS INFORMATION AGREEMENT

STATEMENT OF PRIVACY LAWS AND UNIVERSITY POLICY

It is the legal and ethical responsibility of all UCSF faculty, staff, house staff, students, trainees, volunteers, and contractors to use, protect, and preserve personal and confidential patient, employee, student, and University business information, including medical information for clinical or research purposes (referred to here collectively as "Confidential Information"), in accordance with state and federal laws and University policy.

Laws controlling the privacy of, access to, and maintenance of Confidential Information include, but are not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), the HIPAA Final Omnibus Rule, the California Information Practices Act (IPA), the California Confidentiality of Medical Information Act (CMIA), and the Lanterman- Petris-Short Act (LPS), and the Family Educational Rights and Privacy Act of 1974 (FERPA). These and other laws apply whether the information is held in electronic or any other format, and whether the information is used or disclosed orally, in writing, or electronically.

University policies that control the way Confidential Information may be used include, but are not limited to, the following: UCSF Medical Center Policies 05.01.04 and 05.02.01, LPPI Policies, UCSF Policy 650- 16 Minimum Security Standards, UCSF Policy 130-00 Disclosure of Information from Student Records, UC Standards of Ethical Conduct--University Resources, UC Personnel Policies PPSM 80 and APM 160, applicable union agreement provisions, and UC Business, UC Business and Finance Bulletin IS-3 Electronic Information Security, and Finance Bulletin RMP 8.

"Confidential Information" includes information that identifies or describes an individual, the unauthorized use, access or disclosure of which (a) is prohibited by federal or state laws, or (b) would otherwise constitute an unreasonable invasion of personal privacy. Examples of confidential employee and University business information include home address, telephone number, medical information, date of birth, citizenship, social security number, spouse/partner/relative names, income tax withholding data, performance evaluations, proprietary/trade secret information, and peer review/risk management information and activities. Most information in student records is confidential.

"Medical Information" includes the following no matter where it is stored and no matter the format: medical and psychiatric records, photos, videotapes, diagnostic and therapeutic reports, x-rays, scans, laboratory and pathology samples, patient business records (such as bills for service or insurance information), visual observation of patients receiving medical care or accessing services, and verbal information provided by or about a patient. Medical Information, including Protected Health Information (PHI), is maintained to serve the patient, health care providers, health care research, and to conform to regulatory requirements.

Unauthorized use, disclosure, viewing of, or access to Confidential Information in violation of state and/or federal laws may result in personal fines, civil liability, licensure sanctions and/or criminal penalties, in addition to University disciplinary actions.

University Privacy Policy and Acknowledgement of Responsibility

I understand and acknowledge that:

- It is my legal and ethical responsibility as an authorized user to preserve and protect the privacy, confidentiality and security of all Confidential Information relating to UCSF, its patients, students, activities and affiliates, in accordance with applicable laws and University policy.
- I will access, use and disclose Confidential Information only in the performance of my University duties, when required or permitted by law, and disclose information only to persons who have the right to receive that information. When using or disclosing Confidential Information, I will use or disclose only the minimum information necessary.

- I will discuss Confidential Information for University-related purposes only. I will not knowingly discuss any Confidential Information within hearing distance of other persons who do not have the right to receive the information. I will protect Confidential Information which is disclosed to me in the course of my relationship with UCSF.
- Special legal protections apply to and require specific authorization for release of mental health records, drug abuse records, and any and all references to HIV testing, such as clinical tests, laboratory or others used to identify HIV, a component of HIV, or antibodies or antigens to HIV. I will obtain such authorization for release when appropriate.
- My access to all University electronic information systems is subject to monitoring and audits in accordance with University policy.
- My User ID(s) constitutes my signature and I will be responsible for all entries made under my User ID(s). I agree to always log off of shared workstations.
- It is my responsibility to follow safe computing guidelines.
    - I will use **encrypted** computing devices (whether personal or UCSF-owned), such as desktop computers, laptop computers, tablets, mobile phones, flash drives, and external storage, **for any UCSF work purpose** which involves the use, exchange, or review of Protected Health Information or Personally Identifiable Information, including but not limited to, clinical care, quality reviews, research, educational presentations/conferences, and financial or personnel-related records. Encryption must be a UCSF-approved solution.
    - **I may be personally responsible** for any breach of confidentiality resulting from an unauthorized access to data on an unencrypted device due to theft, loss or any other compromise. I will contact the UCSF IT Service Desk at (415) 514-4100 for questions about encrypting my computing device.
    - I will not share my **Login or User ID and password** with any other person. If I believe someone else has used my Login or User ID and password, I will immediately report the use to the UCSF IT Service Desk at (415) 514-4100 and request a new password.
- Under state and federal laws and regulations governing a patient's right to privacy, unlawful or unauthorized access to or use or disclosure of patients' Confidential Information may subject me to civil fines for which **I may be personally responsible**, as well as criminal sanctions. Under University policy, I may also be subject to disciplinary action up to and including immediate termination from my employment/professional relationship with UCSF.

By signing below:

- **I attest that I have encrypted or will encrypt all of my personal computing devices before using them for any UCSF work purpose, unless I have an encryption exception approved by the UCSF Information Security Officer. I will not use an unencrypted computing device for UCSF work purposes without an approved exception.**
- **I attest I have read, understand, and acknowledge all of the above STATEMENTS OF UNIVERSITY PRIVACY POLICY and the ACKNOWLEDGEMENT OF RESPONSIBILITY.**

Signature	Date: 3/19/2024
Print Name	UCSF Department: Anesthesia & Periop Care
UCSF Employee Number	Signature of Manager or UCSF Representative
☐ Non-UCSF Employee	Print Manager or UCSF Representative Name: Michael Gropper

UCSF Medical Center

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

CONSENT FOR PRESENCE OF OBSERVER DURING MEDICAL PROCEDURE AND NURSING CARE

OBSERVER OF MEDICAL PROCEDURE / NURSING CARE

I, the Observer, understand that during the medical procedure/ nursing care named below (page 2), the involved physicians and hospital staff must devote their full attention to the patient. I therefore agree to:

A. Bring to the attention of the attending physician and the hospital nursing staff any medical problems I have which could interfere with the care of the patient. Such problems might include but are not limited to:

- Lapse of consciousness problems, such as fainting, epilepsy, narcolepsy, etc.
- Heart problems
- Convulsions
- Diabetes
- Claustrophobia
- Weak stomach
- Cough, flu, cold
- Communicable diseases

B. Conform to all UCSF Medical Center rules and regulations.
C. Comply with all orders and directions of the physicians and hospital or other UCSF personnel.
D. Leave the area immediately if considered necessary by the physicians or hospital personnel.
E. Maintain strict confidentiality regarding all patient care information.

I have been instructed by the attending physician/ RN concerning routine practices utilized during the procedure/ nursing care named on page 2. I hereby release UCSF Medical Center, their physicians, nursing staff, officers, directors, agents and employees from any liability in the event of my presence during the procedure results in injury to me, the patient or to others.

OBSERVERS(S) REQUESTING PATIENT CONSENT TO OBSERVE MEDICAL PROCEDURES AND NURSING CARE

Name (Print):_____ Signature:_____ Date:_____
(Observer / legal guardian) *(Observer / legal guardian)*

Name (Print):_____ Signature:_____ Date:_____
(Observer / legal guardian) *(Observer / legal guardian)*

Name (Print):_____ Signature:_____ Date:_____
(Observer / legal guardian) *(Observer / legal guardian)*

Name (Print):_____ Signature:_____ Date:_____
(Observer / legal guardian) *(Observer / legal guardian)*

Name (Print):_____ Signature:_____ Date:_____
(Observer / legal guardian) *(Observer / legal guardian)*

UCSF

PATIENT NAME

DR. NAME

TOPIC

DATE:	TIME:

LOCATION

CONSENT FOR PHOTOGRAPHY / AUTHORIZATION FOR PUBLICATION

I hereby give my consent for photography, filming, videotaping and/or audio recording or other means of capturing my image or voice and/or being quoted in the media or printed materials (including social media websites) at UCSF and hereby authorize release of such to:

_____

_____

Check one of the following:

I am a/an Patient ☐ (or) Patient's surrogate (legal representative) _____.

Staff ☐, Volunteer ☐, Visitor ☐, Other (describe) _____.

I authorize the use or disclosure of such for the following purposes ***(check all that apply):***

☐ Research Activities (faculty, staff or vendors).

☐ External Teaching (Publication in scholarly journals and textbooks; educational seminars, conferences and scientific exhibits/illustration; educational lectures to professional and public groups, etc.).

☐ Marketing, Advertising and Media (Public Relations and charitable goals: UCSF publications and websites, printed materials, news reporting, documentary films, commercials, television or film, social media websites, etc.).

☐ Other uses (describe): _____

THE FOLLOWING QUESTIONS ARE APPLICABLE TO PATIENTS ONLY:

Please specify the types of health information regarding your medical condition or treatment you authorize for release: _____.

Dates of Treatment: _____.

The following information will not be released unless you specifically authorize it by initialing the relevant line(s) below:

_____ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. Sections 2.34 and 2.35).

_____ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (W&I Code Section 5328).

_____ I specifically authorize the release of HIV/AIDS test results (H&S Code Section 120980(g)).

_____ I specifically authorize the release of genetic testing information (H&S Code Section 124980(j)).

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such disclosure may no longer be protected by state or federal confidentiality laws.

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

862-002A (Rev. 09/11) WorkflowOne ORIGINAL - MEDICAL RECORD COPY YELLOW - PATIENT COPY

UCSF

PLEASE DESCRIBE SUBJECT:

DATE:	TIME:

CONSENT FOR PHOTOGRAPHY / AUTHORIZATION FOR PUBLICATION

THE FOLLOWING IS APPLICABLE TO PATIENTS AND NON-PATIENTS:

I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold UCSF and its personnel and affiliated programs harmless from any and all liability which may or could arise from activities authorized by this agreement.

This authorization expires on _____. If no date given, authorization will expire 12 months after the date of signature of this form. Upon expiration of this Authorization, UCSF will not permit further release of any photography or information, but will not be able to call back any photography or information already released.

I may request cessation of filming or recording at any time. I may rescind this Authorization up until a reasonable time before the photography or information is used, but I must do so in writing.

I have a right to receive a copy of this Authorization.

UCSF will ☐ will not ☐ receive compensation for the use or disclosure of my photography or information. _____

UCSF Contact Information:

_____

PATIENT SIGNATURE:

Signature: _____ Date: _____

(patient or patient's surrogate)

If signed by someone other than the patient, indicate relationship:

_____

Print name: _____

(patient or patient's surrogate)

Contact Information (Name, address, phone number & email address):

_____

_____

Witness _____ Date: _____

Language: English ☐ Other _____

Interpreter used (in person): ☐ (telephone) ____

Interpreter Name (please print): _____

NON-PATIENT SIGNATURE:

Signature: _____ Date: _____

Print Name: _____

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