



HIGH SCHOOL/COLLEGE INTERNSHIP/SHADOWING REQUEST

CONFIDENTIALITY STATEMENT

During this observation time I understand patient's individual health information which is disclosed is confidential. I may become aware of this information via written, oral or electronic data. Minnesota Orthopedic Sports Medicine Institute/ Twin Cities Orthopedics expects that any discussion, access, storage, interpretation, release or handling of this confidential information will be treated with care and caution.

By signing below- I understand this is an agreement set forth for the date range shown on the front page and I also understand the Confidentiality Statement.

Signature: _____ Date: ____/____/20____
Shadowing/Interning Student's Signature

If student is a minor (under the age of 18), parent signature needed:

Signature: _____ Date: ____/____/20____
Parent/Guardian's Signature

EMERGENCY CONTACT INFORMATION

Information of individual to contact in the event of an emergency:

Name(s): _____

Relationship to you: _____

Home Phone: (____) ____-____ Work Phone: (____) ____-____ Cell Phone: (____) ____-____

Return completed form to:
Minnesota Orthopedic Sports Medicine Institute-Eden Prairie
Attn: Becky Stone
775 Prairie Center Drive #250
Eden Prairie, MN 55344
Phone: (952) 995-8765
Fax: (952) 944-0460