



Today's Date: (mm/dd/yyyy) \_\_\_\_\_

Are you volunteering to fulfill a community service requirement or on behalf of a company, school, organization or church?  No  Yes

If "Yes", name of the company, school, organization or church: \_\_\_\_\_

Are you currently a student?  No  Yes

If "Yes", school you currently attend and major: \_\_\_\_\_

**VOLUNTEER INFORMATION**

Full name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Telephone: \_\_\_\_\_  Cell  Home

Date of Birth: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Telephone: \_\_\_\_\_

Relationship to Emergency Contact: \_\_\_\_\_

**RELEASE**

**Please read this information carefully before signing below!**

In return for receiving permission from the Autism Collaborative Center of Eastern Michigan University to allow me to participate as a volunteer at an Agency sanctioned event, or at an Agency affiliated site, I agree to assume all risks of loss and injury that may arise out of participation. I hereby FULLY and FINALLY RELEASE, DISCHARGE and agree to INDEMNIFY and HOLD HARMLESS the Autism Collaborative Center and their respective agents, officers, employees and affiliates, from any and all liability, claims, demands and causes of action whatsoever, related to any loss or damage to my person or property, including injury, death, and any and all losses, damages, expenses, costs, fees and/or liabilities of whatsoever kind or nature in connection therewith whether anticipated or unanticipated. This release shall be binding on me, my heirs, successors, assigns, administrators and/or executors.

I understand that engaging in Autism Collaborative Center's volunteer activities may expose me to dangers both from known and unanticipated risks. I realize that working on this project may involve the use of tools as well as intense physical labor. I am aware of the risks and hazards inherent in participating and do hereby assume sole responsibility for all such risks and waive all recourse against Autism Collaborative Center.

I agree to abide by the guidelines and direction of Autism Collaborative Center while taking part in this project. I hereby acknowledge that I have read, understood and do voluntarily sign the foregoing release.

**PHOTOGRAPHIC RELEASE:**

Do you object to the Autism Collaborative Center (ACC) photographing you during the course of your participation as a volunteer and using the images for ACC related publicity purposes?

Yes, I object  No, I don't object

*\*\*Please advise the project leader or photographer if you have checked "Yes".*

Print Your Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Guardian if volunteer is under 18: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to volunteer: \_\_\_\_\_

**Autism Collaborative Center**  
**Eastern Michigan University**  
1055 Cornell St., Fletcher School  
Ypsilanti, MI 48197  
(734) 485-2890

### **Confidentiality Agreement**

All EMU Autism Collaborative Center client information whether contained in a client's Clinic record, or in any other medium, including audio, videotapes, or any computer system is strictly confidential. Disclosing, accessing, or permitting access to confidential client information without proper authorization is a violation of EMU Autism Collaborative Center policy, state laws and Federal laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and unauthorized disclosures may result in disciplinary action. In addition, disclosing, accessing, or permitting access to confidential Protected Health Information (PHI) without proper authorization may also subject the violator to civil and/or criminal penalties for violation of state laws and HIPAA. Billing and financial management information is also to be held in strict confidence and is not to be disclosed without written authorization by the client.

I certify that as a **practicum student, staff, volunteer, or faculty member** of the EMU Autism Collaborative Center, I understand the statements above and am aware of the confidential nature of the client's PHI. I understand and agree that in the performance of my duties at the EMU Autism Collaborative Center, I am obligated to respect client privacy and to protect client PHI from unauthorized use and/or disclosure. This includes only accessing client's PHI on a need to know basis related to treatment, payment, and health care operations, or training. I understand that when the audio or videotapes for a client are in my possession, I assume total responsibility for the confidential retention and viewing of these tapes. I understand that the unauthorized use and/or disclosure of information from the client's record, audio or videotapes, or from any computer system may result in disciplinary action up to and including dismissal, in accord with the policy outlined in the EMU Autism Collaborative Center Policy and Procedures Manual, and may further subject me to civil and criminal penalties under HIPAA.

I acknowledge that I may have access to confidential client information. By signing this statement, I agree to follow the guidelines below, and as further detailed in the EMU Autism Collaborative Center Policy and Procedures Manual.

The identity of clients, or information that would reveal the identity of clients, cannot be revealed without the specific permission of the client. The only exceptions to this are cases in which the client may be dangerous to themselves or others and in cases of child abuse. In such situations, there may be legal requirements that responsible agencies be informed. There are also certain legal proceedings in which case notes and other records can be ordered to be released by the courts. Clinicians must familiarize themselves with, and adhere to, confidentiality procedures of the Clinic and the laws of the State. Case material discussed in class must be prepared in such a way that client confidentiality is maintained.

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

\_\_\_\_\_  
Position in Clinic

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**BACKGROUND AUTHORIZATION REQUEST**

By signing this authorization, the applicant grants permission to the Michigan State Police (MSP) and any other public or private entity to conduct a background check for the express purpose of determining eligibility for working with youngsters in an academic environment. The background search will include, but is not limited to, arrests, criminal charges, criminal convictions, and information regarding criminal justice contacts.

I affirm that I have read and fully understand the above paragraphs and I consent to the aforementioned background check.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Name of candidate – Last</b>	<b>First</b>	<b>Middle</b>
<b>Date of birth:</b>	<b>Sex:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	
<b>Race:</b>  <input type="checkbox"/> White	<input type="checkbox"/> Black (African American)	<input type="checkbox"/> American Indian/Alaskan Native
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Other: _____

THIS INFORMATION IS CONFIDENTIAL. DISCLOSURE OF CONFIDENTIAL INFORMATION IS PROTECTED BY THE FEDERAL PRIVACY ACT.	AUTHORITY: 1935 PA 59 COMPLIANCE: VOLUNTARY
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