



Lane Regional
Medical Center

1100 Oregon Street, Medford, Oregon 97504

LANE REGIONAL MEDICAL CENTER
PRIVILEGES APPLICATION FORM
LASER

R G A

___ ___ ___ CO2

___ ___ ___ CO2 Laser Resurfacing

___ ___ ___ CO2/FLPDL wart removal

___ ___ ___ FLPDL treatment of birthmarks/vascular lesions

___ ___ ___ Ablation of condyloma

___ ___ ___ Agron

___ ___ ___ Flash-Lamp Pulsed Dye Laser

___ ___ ___ YAG

___ ___ ___ Nd: YAG treatment of pigmented lesions/tatoos

Applicant signature _____ Date _____

STATEMENT OF CONFIDENTIALITY

It is the policy of Lane Regional Medical Center and the Medical Staff that any and all information concerning a patient of the facility is of a strictly confidential nature. THIS APPLIES TO VERBAL, WRITTEN OR FAX TRANSMISSIONS. Confidentiality is a right entitled to each patient beginning at admission or upon making a reservation for admission and the right is never terminated. It is the duty and responsibility of every physician, employee and volunteer of Lane Regional Medical Center to ensure that right, both at work and off duty.

By signing below, I signify that I understand and agree to the following:

1. I acknowledge that all information in the patient record (a medical/legal document) including evidence of patient identity as well as the course of clinical treatment is strictly confidential. I will abide by the policy of Lane Regional Medical Center and I will not jeopardize the patient's right to confidentiality (either verbally, in writing or via Fax transmission) of any information which may be used to identify a patient.
2. I agree that in reviewing records, data or hospital documents containing patient information that this information will be used only for the treatment of the patient.
3. I further understand that I could be subject to legal action for violation of any confidences related to patient information.

Name _____
(Please Print)

Signature

Date