



Lane Regional  
Medical Center

Commercial and Governmental

LANE REGIONAL MEDICAL CENTER  
PRIVILEGES APPLICATION FORM  
PSYCHIATRY

R G A

- Administration psychiatry
- Biofeedback therapy
- Child psychiatry
- Counseling of individuals with problems related to drug and alcohol abuse
- Counseling, individual, marital and family group
- Consultation with community service
- Consultation/liaison psychiatry
- Diagnostic testing and assessment
- Family and marital therapy
- Forensic psychiatry
- Group psychotherapy
- Hypnotherapy
- Individual psychotherapy
- Inpatient psychiatric treatment
- Life threatening emergency. At time of a clinical emergency any practitioner may render
- Neuropsychological testing
- Psychopharmacotherapy
- Relaxation therapy
- Social work treatment of individuals, couples, families and groups
- Systematic desensitization
- Vocational and career counseling

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

PHYSICIAN

STATEMENT OF ACKNOWLEDGMENT

This is to verify that I have received a copy of the following notice to physicians:

NOTICE TO PHYSICIANS: Medicare/Champus payments to hospital is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal Funds may be subject to fine, imprisonment, or civil penalty under applicable Federal law.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_, M.D.  
Printed Name