Cincinnati Children's Hospital Medical Center

Student Confidentiality Agreement

It is important to recognize that protected health information (PHI) includes medical records relating to a patient's past, present and future care and treatment as well as billing records related to that care which contains any of the following identifiers:

- Names
- Geographic subdivisions smaller than a state
- Telephone/fax numbers
- E-mail addresses
- Social Security Numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- All elements of dates related to individual
- Certificate/license numbers
- Vehicle identifiers/serial numbers
- Device identifiers/serial numbers
- URL's
- Internet protocol address number
- Biometric identifiers (finger/voice prints)
- Full face photo image
- Any other unique identifying number, characteristic, or code

I understand that _____ (here and after referred to as Facility) has a legal and ethical responsibility to maintain patient privacy, including obligations to protect the confidentiality of patient protected health information ("PHI") and to safeguard the privacy of patient and facility information. In addition, I understand that during the course of my affiliation as a student/faculty with the Facility, I may see or hear other Confidential Information such as financial data and operational information that the Facility is obligated to maintain as confidential.

The term of this Confidentiality Agreement is from _____, 200__, through _____, 200__, the length of my clinical rotation at the Facility.

As a condition of my affiliation as a student and/or precepting faculty member with the Facility I understand that I must sign and comply with this Agreement.

I will use and disclose PHI and/or Confidential Information only if such use or disclosure complies with the Facility Policies and Procedures, and is required for the performance of my responsibilities as a student or precepting faculty in the care and treatment of patients. The use and disclosure of PHI and/or Confidential Information for the purpose of care and treatment of patients does not include the use or disclosure of PHI and/or Confidential Information for educational endeavors such as writing educational reports for my course of study, engaging in seminars and presentations in the educational setting.

My personal access code(s), user ID(s), access key(s) and password(s) used to access Facility computer systems or other equipment are to be kept confidential at all times.

Since the use of PHI and Confidential Information includes access, I will not access or view any PHI or Confidential Information other than what is required to perform my responsibilities as a student and/or precepting faculty in the care and treatment of patients. If I have any questions, I will immediately ask my precepting faculty or the Privacy Officer of the Facility for clarification.

I will not discuss any information pertaining to patient PHI or the Facility in an area where unauthorized individuals may hear such information (for example, in hallways, on elevators, in the cafeteria, on public transportation, at restaurants, and at social events). I understand that it is not acceptable to discuss any PHI or Confidential Information in public areas even if specifics such as patient's name are not used.

I will not make inquiries about any PHI for any individual or party for whom I am not authorized to have such information as a part of my involvement in patient care and treatment. In addition I will not ask other persons to obtain PHI or Confidential Information knowing that that person does not have the authority to access such information on my behalf.

I will not make any unauthorized transmissions, copies, disclosures, inquiries, or modifications of PHI or Confidential Information. Such unauthorized transmissions include, but are not limited to, removing and/or transferring PHI or Confidential Information from the Facility's computer systems to unauthorized locations (for instance, my home or school computer).

Upon termination of my affiliation with the Facility, I will immediately return all property (e.g. keys, documents, ID badges, etc.) to my precepting faculty and the Facility. **I understand that it is my obligation to return all patient PHI to my precepting faculty and the Facility upon completion of my clinical rotation at the Facility. Faculty are responsible for the destruction of PHI, whether hard copy or electronic.**

I agree that my obligations under this Agreement regarding PHI and Confidential Information will continue after the termination of my affiliation with the Facility.

I understand that violation of this Agreement may result in disciplinary action, up to and including termination of my affiliation with the Facility and/or suspension, restriction or loss of privileges in accordance with the Facility's Policies and Procedures, as well as potential personal civil and criminal legal penalties.

I understand that any PHI or Confidential Information that I access or view at the Facility does not belong to me.

I am aware that the Facility reserves and intends to exercise the right to review, audit, intercept, access, and act upon inappropriate use of the Facility's computer systems at any time, with or without user notice and that such access by the Facility may occur during or after working hours.

The intent of this Agreement is to ensure that students and their faculty preceptors comply with HIPAA Regulations and the Facility Privacy Policies and Procedures.

I have read the above Agreement and agree to comply with all its terms as a condition of my continued affiliation with the Facility.

_____ _____

Student Signature Date

_____

Print Your Name

_____

School