Instructions:
Print, read and complete the bottom portion of this document. Submit completed document to Academic Programs Office, K6/146.

UWHC CONFIDENTIALTY AGREEMENT

The University of Wisconsin Hospitals and Clinics Authority ("UWHC") provides learning experiences for health science students from outside our settings. These students have the opportunity to observe and participate in the care of UWHC patients. Federal and state laws, accreditation standards, and professional ethics require that all health science students maintain the confidentiality of patient information to the greatest extent possible. The purpose of this agreement is to establish the following understanding between UWHC and the health science student regarding confidentiality of patient information.

I understand that I am responsible for reading and understanding the attached HIPAA training document. Should I have questions regarding the content, I will consult with my clinical supervisor and/or UWHC's HIPAA Privacy Officer.

I understand that during my participation in my clinical experience, I may come in contact with the PHI of UWHC's patients. PHI means any information that identifies a patient, including demographic, financial, and medical, that is created by a health care provider or health plan that relates to the past present or future condition, treatment, or payment of the individual.

I understand that PHI includes all patient identifiable information in any medium, including, but not limited to oral, written, hard copy, and electronic (whether retrieved on screen or contained on a computer disc).

I understand that PHI is to be held in strict confidence and I agree that I will not:

1. Review any individually identifiable information not directly related to my participation in an educational experience.
2. Discuss any PHI with anyone who does not have a legitimate, professional need-to-know the information.
3. Disclose the information to any person or organization outside UWHC without proper, written authorization from the patient.

I understand that the obligations outlined above will continue after my participation in this educational experience.

I understand that violation of any of the above will result in termination from participation in the educational experience and may lead to civil and/or criminal penalties pursuant to the Health Insurance Portability and Accountability Act of 1996.

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Signature of Student **Date**

Nursing Program (circle one): Undergraduate | Graduate