Fox Valley Healthcare Alliance Confidentiality Agreement
STUDENT/FACULITY

I, (*please print*) _____ a (*please circle*) Student/Faculty of _____, understand that during my engagement with the Healthcare Facility (Member of the FVHCA), I may have access to or come in contact with confidential patient, business, practioner, or provider information. The Healthcare Facility defines "confidential information" to include any and all information incorporated in or pertaining to:

1. Patient identities, diagnoses, treatments, or other patient medical or health services.
2. Medical Records
3. Practitioner or provider practice review information.
4. Claims, claim payment and/or reimbursement data and information.
5. Proprietary business information, customer identities, business or strategic plans.
6. Healthcare Facility financial information.
7. Policies, procedures.

This information may be in any form (e.g. oral, written or electronic) and any format (e.g. individual records, summaries or consolidated reports, and/or internal or external report(s).

Student/Faculty agrees to maintain strict confidentiality of any accessed information as described above and disclose it to third parties only if; a) authorized in writing by Healthcare Facility and, as appropriate, by the patient, practitioner, or provider involved, and/or b) as required by law. This can include, but is not limited to, protecting and holding confidential patient information unless parties have authorization to that information, accessing only information that is necessary to perform duties as Student/Faculty, and discussing a patient's medical information only with those directly involved in that patient's care.

In addition, such information should not be transferred to or from, or stored within, any form of personal technology (e.g. personal computers, laptops, cell phones, etc.), nor should it be shared in any form of social media (e.g. Facebook, YouTube, etc.)

I also understand that I am not allowed to access my own patient care record or those of any of my family members or friends/acquaintances without following proper release of information or record viewing procedures.

I understand that I will be subject to, and agree to abide by, the same rules, regulations, policies, procedures and standards of clinical agencies as are established for the organization's employees in matters related to confidentiality.

The organization may, in its sole discretion, terminate my participation in clinical education at the agency for breach of any of the above. I further understand that I could be subject to legal action, including but not limited to lawsuit for invasion of privacy, or unauthorized access or disclosure of confidential patient healthcare information.

Student/Faculty shall, within seven days of discovery of any use, disclosure or contact with any confidential information, report any such use, disclosure or contact to the Healthcare Facility.

Student/Faculty understands that failure to maintain confidentiality may result in liability to Healthcare Facility as well as its patients, practitioners, and providers, and legal action may be taken. The Student/Faculty further agrees to hold harmless and protect Healthcare Facility against any and all claims for damages resulting from any unauthorized disclosure of such information. Student/Faculty understands this obligation survives the termination of Student/Faculty's engagement, and contractor dealings with Healthcare Facility.

_____ _____
Student/Faculty Signature Date

_____ _____
Student/Faculty Signature Date

General On-line Orientation Form

HIPAA & Blood Borne Pathogens: Confirmation of Completion

STUDENT/FACULTY

I, _____ (*please print name)* certify that I have completed the on-line orientation which includes HIPAA and Blood Borne Pathogens. Falsifying this statement or failure to comply with facility policies will result in disciplinary action that may include expulsion from the facility for the remainder of the clinical experience. I know that I am accountable for the site orientation.

_____ _____

Student/Faculty Signature Date

_____ _____

Student Faculty Signature Date

For Affinity students only:

This is to acknowledge that I have viewed the video **Ministry Health Care Regulatory Compliance: It's Good Business (Corporate Integrity video).** I agree to comply with the standards contained in the Guide (and the related policies and procedures) while I am a student within an Affinity Health System facility. This will be expected as a part of my continued association. I acknowledge that the Guide is only a statement of principles for individual and business conduct. It does not constitute an employment contract. This acknowledgement is not an assurance of continued association.

_____ _____

Student Signature Date

Revised August 2011