

Confidentiality and Privacy of Patient Information

Dear Student,

As a student who is rotating in this health care setting and office practice, you have an ethical and legal duty to keep patient information confidential. Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) forbids healthcare providers from disclosing patients' protected healthcare information, except upon written authorization by the patient or as otherwise permitted by the law.

Under the HIPAA Security and Privacy Regulations, hospitals and other healthcare providers are required to have the capacity to determine who is accessing their patients' protected healthcare information and to protect the privacy of that information. Failure to maintain patient confidentiality, accessing patient information without a need to do so for your work, or any other violation of policy, may result in disciplinary action against the student, resident or fellow.

Some general guidelines:

- Access patient information only if you need that information to do your work.
 - Share or discuss patient information only if it is necessary to do your work and only in appropriate locations.
 - If there are electronic health records, never share your identification number or password, and log off computer sessions when you will be away from a workstation.
 - Follow the health care system and provider's policies on confidentiality and privacy.
 - Ensure confidentiality when you handle all protected healthcare information.
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Student Agreement

I have received and reviewed all information that I was given about patient privacy and confidentiality. I understand there are rules regarding the use and disclosure of patient protected healthcare information, and I agree to abide by such rules and keep protected healthcare information confidential. I understand there are both educational and legal punishments if I violate this policy. I recognize that I may be immediately removed and excluded from this program, if I do not comply with this Confidentiality and Privacy Agreement.

Print Name

Signature

Date

**Confidentiality and Privacy of Patient Information
Authorization for Release of Information**

I. Information about the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Date: _____
Patient Name: _____
Medical Record No: _____

As a patient in the practice of Dr. _____,
I, _____ hereby give my permission to allow the following student, _____, to participate in my care during their training period from _____ to _____ (on which date this authorization will expire).

II. Important Information about Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.
- I may see and copy the information described on this form if I request to do so.
- I am not required to sign this form to receive my health care treatment.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity.

III. Signature of Patient or Patient's Representative

The form MUST be completed before signing.

Signature of patient [or] patient's representative

Date

Printed name of the patient's personal representative

Relationship to the patient, including authority for status as representative

Signature of Witness

Date

A copy of the signed, completed Authorization should be given to the Patient.