CONFIDENTIALITY AGREEMENT FOR VISITORS IN CLINICAL AREAS

As a visitor of_____ you are required to conduct yourself in strict conformance to all applicable laws and_____'s policies and procedures. By being in clinical areas, you may encounter confidential Protected Health Information (PHI). _____'s care is often conducted and coordinated in semi-public environments where there is a risk that PHI may be heard or viewed by individuals not directly involved in the patient's care. _____'s policies and procedures are intended to limit the risks of such incidental disclosure of PHI as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You may see or hear information related to _____ patients - such as charts and other paper and electronic records, demographic information, conversations, names of attending physicians, patient financial information, and more. Any PHI you see or hear, either incidentally or by attending exams, must be kept confidential. By signing below you are agreeing to abide by _____'s policies and procedures.

As a condition of and in consideration of my use, access, and/or disclosure I understand and agree to the following:

☐ I will access, use, and disclose confidential information only as permitted by_____. This means I will only access, use, and disclose confidential information that I have been given the authorization to access, use, and disclose.

☐ I understand that any fraudulent application, violation of confidentiality or any violation of the above provisions will result in the termination of my privilege to observe and participate in exams and/or other practice activity.

☐ My signature below indicates that I have read, accept, and agree to abide by all of the terms and conditions of this Agreement and agree to be bound by it.

_____ _____

Printed Name Signature

_____

Date