UNITED STATES UNIVERSITY

Appendix C

HIPAA CONFIDENTIALITY AGREEMENT

All students must complete this form.

Student Full Name: _____

The discussions, uses and disclosures addressed by this Agreement mean any written, verbal or electronic communications. I understand that I am never to discuss or review any information regarding a patient at a clinical site unless the discussion or review is part of my assignment to the site. I understand that I am obligated to know and adhere to the privacy policies and procedures of the clinical site to which I am assigned. I acknowledge that medical records, accounting information, patient information and conversations between or among healthcare professionals about patients are confidential under law and this Agreement.

I understand that, while in the clinical setting, I may not disclose any information about a patient during the clinical portion of my clinical assignment to anyone other than the medical staff of the clinical site. I understand that I may not remove any record from the clinical site without the written authorization of the site. Additionally, I understand that Patient Protected Health Information (PHI) includes patient medical and financial information or any other information of a private or sensitive nature that is considered confidential. I understand that before I use or disclose patient information in a learning experience, classroom, case presentation, class assignment or research, I must exclude the following:

Names	Certificate/license numbers
Geographical subdivisions smaller than a state	Vehicle identifiers Device identifiers
Dates of birth, admission, discharge, and death	Web locators (URLs)
Telephone numbers and Fax numbers	Internet protocol (IP) addresses
E-mail addresses	Biometric identifiers
Social security numbers	Full face photographs
Medical record numbers	Any other unique identifying number, characteristic, or code
Health plan beneficiary numbers	All ages over 89 years
Account numbers	Any other PHI, financial or confidential information

Additionally, I acknowledge that any patient information, whether or not it excludes some or all of those identifiers, may only be used or disclosed for health care training and educational purposes at United States University, and must otherwise remain confidential. I understand that I must promptly report any violation of the clinical site's privacy policies and procedures, applicable law, or this Agreement, by me, or a United States University student or faculty member to the appropriate United States University Program Director.

I am familiar with the guidelines in place at United States University and in my clinical settings pertaining to the use and disclosure of patient PHI or other confidential information. Prior approval should be obtained before any disclosure of PHI or other confidential information not addressed in the guidelines and policies and procedures of United States University and clinical sites. I understand the HIPAA Video and PowerPoint information and that if I have questions regarding the HIPAA Video and PowerPoint that I need to take my questions to the appropriate Program Director at United States University. I confirm by signing this Agreement, that I have successfully passed the HIPAA Training Quiz.

Finally, I understand that if I violate the privacy policies and procedures of the clinical site, applicable law, or this agreement, I will be subject to disciplinary action. By signing this Agreement, I certify that I have read and understand its terms and will comply with them.

Signature: _____ **Date:** _____