Confidentiality Statement

Through your visit, shadow, or rotations, you may learn of or have access to employee protected health information and protected health information of patients. Protected health information, for employees and patients, is defined as any information that identifies an individual (patient) and describes their health status, sex, age, ethnicity, or other demographic characteristics, in any format (i.e., electronic, written, or oral). Protected health information is to be maintained in a confidential manner. All protected health information is protected by law and by the privacy policies of this facility. The intent of the laws and policies is to ensure that protected health information remains confidential, and that it is used only to provide for employee or patient care and services. Your duties, obligations and responsibilities with regard to confidentiality are described below in the form of an agreement with this facility. You are required to abide by these duties, obligations and responsibilities. Any violation will subject you to discipline, which may include termination of tour, shadow experience, and or clinical rotation and legal liability from the patient and this facility.

Confidentiality Agreement - I, the undersigned visitor or student, agree to the following:

1. I will use protected health information only as needed to perform my legitimate duties as a visitor or student of this facility. This means, among other things, that:

    - I will only access protected health information necessary for the performance of my duties;
    - I will not in any way divulge, copy, release, sell, loan, review, alter or destroy any confidential information, except as properly authorized by my employer; and
    - I will not misuse or act carelessly with protected health information.

2. I will safeguard and will not disclose information that could provide access to protected health information by persons outside of this facility.

3. I will report activities by any person or entity that I suspect may compromise the confidentiality of protected health information. (Reports made in good faith about suspect activities will be held in confidence to the extent permitted by law, including the name of the individual reporting the activities.)

4. I understand that my obligations for maintaining confidentiality of protected health information maintained by this facility will continue after termination of my employment.

5. I understand that I have no right or ownership interest in any protected health information referred to in this agreement. KRMC may at any time revoke my access to confidential information. At all times during my employment, I will safeguard and retain the confidentiality of all protected health information.

6. I will be responsible for any misuse or wrongful disclosure of confidential information and for my failure to safeguard my means of access to confidential information. I understand that my failure to comply with this agreement may result in legal liability and/or my loss of employment.

Name _____ Signature _____

Contact Information (Phone Number) _____

Affiliated Organization (Reason for Visit) _____

Individual Shadowing _____