HIPAA Confidentiality Agreement

STUDENT/VOLUNTEER CONFIDENTIALITY AGREEMENT

Confidential information includes protected health information (PHI) as defined by the federal Health Insurance Portability and Accountability Act (HIPAA).

Protected Health Information ("PHI") under HIPAA is defined as information that is received from, or created or received on behalf of Sonshine Therapy or its affiliated health care organizations and is information about an individual which relates to past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.

PHI includes medical records, student records, and financial or billing information relating to a patient's or student's past, present or future mental or physical condition; or past, present or future provision of healthcare; or past present or future payment for provision of healthcare and contains any of the following identifiers that may be used to identify the patient or student in relation to PHI.

- Names
- Geographic subdivisions smaller than a state _
- Telephone/fax numbers
- E-mail addresses
- Social Security Numbers
- Medical Record Numbers
- Health plan beneficiary numbers
- Account numbers
- All elements of dates related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89
- Certificate/license numbers
- Vehicle identifiers and serial numbers including license numbers
- Device identifiers/ serial numbers
- Web Universal Resource Locators (URLs)
- Internet Protocol (IP address number)
- Biometric identifier (voice, finger prints)
- Full face photo image
- Any other unique identifying number, characteristic, or code

I understand that Sonshine Therapy and its affiliated health care organizations have a legal and ethical responsibility to maintain and protect the privacy and confidentiality of protected health information (PHI) and to safeguard the privacy of patient and student and Sonshine Therapy and its affiliated health care organizations' information. In addition, I understand that during the course of my affiliation as a student/faculty/staff at Sonshine Therapy and its affiliated health care organizations, I may see or hear other Confidential Information such as financial data and operational information that Sonshine Therapy and its affiliated health care organizations are obligated to maintain as confidential.

The term of this Confidentiality Agreement is the length of my affiliation with and during clinical rotations at Sonshine Therapy. As a condition of my affiliation as a student, staff, and/or precepting faculty member with Sonshine THerapy and its affiliated healthcare organizations I understand that I must sign and comply with this Agreement.

I agree that my obligation under this Agreement regarding PHI and Confidential Information will continue after the termination of my affiliation with Sonshine Therapy. I understand that violation of this Agreement may result in disciplinary action up to and including termination of my affiliation with Sonshine Therapy and/or suspension, restriction or loss of privileges in accordance with Sonshine Therapy's Policies and Procedures, as well as potential personal civil and criminal legal penalties.

I understand that any PHI or Confidential Information that I access or view at Sonshine Therapy and its affiliated health care organizations does not belong to me.

I understand that any access to PHI for research purposes requires proper documentation and approval according to HIPAA policies.

I am aware that Sonshine Therapy and its affiliated health care organizations reserves and intends to exercise the right to review, audit, intercept, access, and act upon inappropriate use of computer systems at any time, with or without user notice, and that such access by Sonshine Therapy and its affiliated health care organizations may occur during or after working hours.

The intent of this Agreement is to ensure that students and their faculty preceptors and staff comply with HIPAA Regulations at Sonshine Therapy and its affiliated health care organizations Privacy Policies and Procedures.

I will use and disclose PHI and/or Confidential Information only if such use or disclosure complies with the Policies and Procedures, and is required for the performance of my responsibilities as a student, staff or precepting faculty in the care and treatment of patients or provision of services to students. The use and disclosure of PHI and/or Confidential Information for the purpose of care and treatment of patients does not include the use or disclosure of PHI and/or Confidential information for educational endeavors such as writing educational reports for my course of study, engaging in seminars and presentations in the educational setting.

My personal access code(s), user ID(s), access key(s) and password(s) used to access Sonshine Therapy and its affiliated health care organizations computer systems or other equipment are to be kept confidential at all times.

Since the use of PHI and Confidential Information includes access, I will not access or view any PHI or Confidential Information other than what is required to perform my responsibilities as staff, student and/or precepting faculty in the care and treatment of patients or service to students. If I have any questions, I will immediately ask my precepting staff at Sonshine Therapy and its affiliated organizations for clarification.

I will not discuss any information pertaining to patient PHI or the health care organization in an area where unauthorized individuals may hear such information (for example), in hallways, on elevators, in the cafeteria, on public transportation, at restaurants, and at social events). I understand that it is not acceptable to discuss any PHI or Confidential Information in public areas even if specifics such as patient's name are not used.

I will not make any unauthorized transmissions, copies, disclosures, inquiries, or modifications of PHI or Confidential Information. Such unauthorized transmissions include, but are not limited to, removing and/or transferring PHI or Confidential Information from Sonshine Therapy's and its affiliated health care organizations' computer systems to unauthorized locations (for instance, my home or school computer).

Upon termination of my affiliation with Sonshine Therapy and its affiliated health care organizations, I will immediately return all property (e.g. keys, documents, ID badges, etc.) to my precepting staff. I understand that it is my obligation to return all patient PHI to my precepting faculty and the health care organization upon completion of my clinical rotation at the health care organization. Faculty are responsible for the destruction of PHI, whether hard copy or electronic.

I have read the above Agreement and agree to comply with all its terms as a condition of my continuing affiliation with Sonshien Therapy.

Signature: ____ Date: ___________

Printed Name: _______________________________________

Sonshine Therapy
Student Department