HIPPA Confidentiality and Non-Disclosure Statement

Please submit completed statement to:
observerships@entnet.org

I, _____, who will be participating as an unpaid observership in the office of _____, am aware of the Practice's Regulations and Policies that are issued under the Health Insurance Portability and Accountability Act of 1996 (also known as the HIPAA Privacy Rule).

- I understand that all patient information, including medical records, other medical information, billing and financial data, is confidential.
- I agree to keep all patient information confidential.
- I agree to comply with all Hospital Privacy Policies and Procedures including those implementing the HIPAA Privacy Rule.
- I understand that if I violate patient confidentiality by using or disclosing patient information improperly, I may be subject to disciplinary action including having my Internship immediately terminated.
- I understand that if I have any questions or concerns about the Privacy Rule and/or the proper use or disclosure of patient information, I shall ask my supervising attending, the Hospital Privacy Officer, or the Hospital Compliance Officer.
- I understand and agree that the Hospital Privacy Policies and Procedures will apply to all patient information even after my observership has been completed.
- I certify that I have read _____'s HIPAA Policy Regarding Confidentiality of PHI and reviewed the HIPAA PowerPoint presentation.
- I understand that no information about any patients I may observe or hear discussed during the observership or at any time thereafter may be transmitted to any third party or person (except other members of the clinical team caring for the patient) via text message, posting on any social network or another online site, or via any other written or verbal communication.

Observer Name: _____

Observer Signature: _____ **Date:** _____

If applicable:

Parent or Legal Guardian Name: _____

Parent or Legal Guardian Signature: _____ **Date:** _____