

HIPAA COMPLIANCE AGREEMENT

AND

CONFIDENTIALITY AND NONDISCLOSURE STATEMENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the American Recovery and Reinvestment Act ("ARRA"), corresponding regulations and applicable state laws govern the use and release of patient identifiable information by health care providers and other entities involved in patient care and payment for such care. These laws establish protections to preserve the confidentiality of health and personal information and specify that such information may not be disclosed except as authorized by law or the patient or individual. I acknowledge that during the course of my association with Skyline Hospital, hereinafter known as Facility, I may have access to confidential patient health information and other confidential Facility information which is defined under HIPAA as protected health information ("PHI"). Therefore, in consideration of my association with Facility, I agree to handle such information in a confidential manner and agree to the following:

1. I agree to comply with all of Facility policies and procedures that are provided to me.
2. I agree that I will maintain the confidentiality of all patient identifiable and other confidential Facility information that I may have access to or see in connection with my with association with Facility.
3. I agree that I will use and disclose confidential health information only in connection with and for the purpose of performing my assigned duties and responsibilities with Facility, as required or permitted by law, and in a manner consistent with Facility policies and procedures.
4. I agree to not use such information or disclose such information to anyone outside of Facility's workforce unless and except as specifically permitted by Facility in writing.
5. I agree to follow Facility's procedures that are provided to me for disposing of any PHI, if applicable and only as instructed by employees of Facility.

6. I agree not to remove any PHI from Facility and will not bring home or to school any personally identifiable information of patients. I will not use any PHI in my school reports or discuss and release any PHI with anyone outside of Facility or create any improper disclosure. If I need to describe my clinical experiences in my coursework, I will only use de-identified data as defined under HIPAA. I understand that in order for the data to be considered de-identified, the following unique identifying information must be removed:

- a. Name;
- b. Address, including street address, city, county, and zip code;
- c. Names of relatives;
- d. Name of employers;
- e. Birthdate
- f. Telephone numbers;
- g. Fax numbers;
- h. Electronic mail addresses;
- i. Social security number;
- j. Medical record number;
- k. Health plan beneficiary number;
- l. Account number;
- m. Certificate/license number;
- n. Any vehicle or other device serial number;
- o. Web Universal Resources Locator (URL)
- p. Internet Protocol (IP) address number;
- q. Finger or voice prints;
- r. Photographic images; and
- s. Any other unique identifying number, characteristic, or code that I would have reason to believe may be available to an anticipated recipient of the information; and I would have no reason to believe that any anticipated recipient of such information could use the information alone or in combination with other information, to identify an individual.

7. I further agree that I will not use the de-identified data for purposes unrelated to my coursework without the prior approval of Facility.

8. I further acknowledge and understand the necessity of maintaining the security and confidentiality of patient health information and that any unauthorized use of disclosure of such information may result in civil and/or criminal penalties under HIPAA or other applicable state laws.

9. If I become aware of a breach or improper disclosure of PHI, I will notify the CTA/Preceptor at Facility immediately.

10. I agree that I will not violate any other federal or state laws, rules or regulations.

Signature

Date

Printed Name