HIPAA/CONFIDENTIALITY of Protected Health Information Acknowledgement/Agreement

Participant Name: ____

As a Midland Health Explorer Post 1950 participant, I agree to follow all rules, policies, and procedures of both my observation site and the Midland Health to the best of my ability.

I also agree to respect the confidential nature of all records and any personal contact I may have with patients. I will adhere to all rules, policies, and procedures pertaining to confidentially regarding all files and identification of patients, former patients, or potential patients for which I come in contact. I will treat all information about any patient as absolutely confidential.

I understand that I am expected to be professional and maintain confidentiality at all times, whether dealing with actual records, projects, or conversations, and abide by the obligations of contractual confidentiality agreements. This includes, but is not limited to conversations, computerized information, and patient charts.

I understand that patient information is not to be accessed, altered, removed, discussed with or disclosed to unauthorized persons, either within or outside the institution. Specifically, I further understand that information regarding a patient's identity, diagnosis, or treatment should never be discussed inside or outside of my volunteer placement.

Additionally, I understand that I am prohibited from having unauthorized possession of confidential records or disclosing information contained in confidential records to unauthorized persons. I understand that I am not to discuss patients or their information with anyone not directly affiliated with the care of the patient or in an instructor capacity, including, but not limited to, any social media outlets. I understand that I am prohibited from taking pictures or recording patients with any electronic devices. I understand that I am also prohibited from disclosing confidential information to unauthorized third parties.

I am aware that Midland Health has a legal responsibility to protect every patient's privacy and any breach of this trust will result in dismissal from the Midland Health Explorer Post 1950. I understand that any violation of this confidentiality requirement will result not only in my dismissal from the Midland Health Explorer Post 1950 but could also result in other appropriate disciplinary and/or legal action being initiated by the Midland Health.

I will report any suspected breaches of confidentiality to a Midland Health Explorer Post 1950 leadership member.

I have read and fully understand the above statements.

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Midland Health Explorer Post 1950 Participant Signature Date

____ ____________________

Witness (Parent/Guardian) Date