HIPAA – Confidentiality of Protected Health Information

Attachment "E"
Memorial Hermann Health System
Student/Intern/Resident/Fellow Confidentiality Agreement

IMPORTANT: Please read all sections. If you have any questions, please ask before signing.

1. **Confidentiality of Patient Information**
   I understand and acknowledge that: (i) services provided to patients are private and confidential; (ii) to enable such services to be performed, patients provide personal information with the expectation that it will be kept confidential and used only by authorized persons as necessary; (iii) all personally identifiable information provided by patients or regarding medical services provided to patients, in whatever form such information may exist, including oral, written, printed, photographic and electronic formats (collectively, the "Confidential Information") is strictly confidential and is protected by federal and state laws and regulations that prohibit its unauthorized use or disclosure; and (iv) in the course of my association with Memorial Hermann Health System, I may be given access to certain Confidential Information.

2. **Disclosure, Use and Access**
   I agree that, except as authorized in connection with my assigned duties, I will not at any time use, access or disclose any Confidential Information to any person (including but not limited to co-workers, friends and family members). I understand that this obligation remains in full force during the entire term of my rotation and continues in effect after such association terminates.

3. **Confidential Policy**
   I agree that I will comply with confidentiality policies that apply to me as a result of my association.

4. **Return of Confidential Information**
   Upon the termination of my association for any reason, or at any other time upon request, I agree to promptly return to Memorial Hermann Health System all copies of Confidential Information then in my possession or control (including all printed and electronic copies).

5. **Periodic Certification**
   I understand that I am required to certify each year that I have complied in all respects with this Agreement.

6. **Remedies**

I understand and acknowledge that: (i) the restrictions and obligations I have accepted under this Agreement are reasonable and necessary in order to protect the interests of patients and Memorial Hermann Health System. I therefore understand that Memorial Hermann Health System may prevent me from violating this Agreement by any legal means available, in addition to corrective measures, which may result in accordance with applicable policies and collective bargaining agreements.

_____ _____
Signature Date

_____
Printed Name

_____ _____
Signature (Parent/Legal Guardian if student under 18) Date

_____
Printed Name (Parent/Legal Guardian if student under 18)

HIPAA – Confidentiality of Protected Health Information Supplemental Form

IMPORTANT: Please read and initial each section. If you have any questions, please ask before signing.

Confidentiality of Patient Information *(Initial Each Section)*	**Initials**
1) ***I WILL NOT*** **email** patient identifiable health information outside of the Memorial Hermann Network. (Patient identifiable information includes, but not limited to: name, date of birth, medical record number and/or account number, insurance member ID#, financial information such as SS# or credit card information and any other number of name that could identify the patient).	
2) ***I WILL NOT*** **print out or copy** patient identifiable health information and take outside of Memorial Hermann facilities.	
3) ***I WILL NOT*** **share** patient identifiable health information with anyone who does not have a treatment relationship with the patient.	
4) ***I WILL NOT*** **copy** any patient identifiable health information to personal computers or thumb/jump drives, etc.	
5) ***I WILL NOT*** send attachments to personal emails with patient identifiable health information.	
6) ***I WILL NOT*** **post** ANY information regarding a patient of Memorial Hermann to any social media platforms. This includes any reference to a patient's presence at any Memorial Hermann facility even if the information does not identify the patient.	

I understand and acknowledge that: (i) the restrictions and obligations I have accepted under this Agreement are reasonable and necessary in order to protect the privacy interests of patients and the Memorial Hermann Health System. I, therefore, understand that Memorial Hermann Health System may prevent me from violating this Agreement by any legal means available including, but not limited to, denying me access to Memorial Hermann facilities or patient identifiable information, any corrective action measures applicable under Memorial Hermann policies and procedures or an institutional affiliation agreement and availing itself of any remedies from a court with jurisdiction in the matter.

_____ _____

Signature Date

_____

Printed Name

_____ _____

Signature (Parent/Legal Guardian if student under 18) Date

_____

Printed Name (Parent/Legal Guardian if student under 18)

MEMORIAL HERMANN

Confidentiality Acknowledgement
Students

Please read the following information carefully. You must sign this acknowledgment to receive an information systems sign on code. By doing so, you will be acknowledging that you understand the policies stated on this form and agree to comply with them fully.

The information stored in the computer systems of Memorial Hermann Healthcare System is confidential. This includes patient information, salaries, salary plans, personal information concerning employees, and all other information.

ALL patient care information is confidential. Patient care information is any information relating to an individual's care at Memorial Hermann Healthcare System. Patient care information includes the paper chart documentation as well as the information in Memorial Hermann's computersystems.

Confidential information is protected by the privacy laws of the United States of America and of the state of Texas. This information may be accessed only by persons who need the information to perform their job duties for Memorial Hermann Healthcare System. Confidential information may be released to persons outside Memorial Hermann only in accordance with Memorial Hermann's procedures for release of information. Patient care information may be released to persons outside Memorial Hermann only for authorized business or legal processes.

Failure to protect confidential information or unauthorized disclosure of confidential information will resultin termination of your access privileges to Memorial Hermann information systems, and will be reported to the Dean of Student Affairs for disciplinary action.

Information stored in Memorial Hermann's computer systems may be accessed only by persons who have been issued user identification codes. Each authorized user of hospital computer systems will have a unique personal password thatis associated with his/her user identification code. Each person is responsible for changing this password periodically (at least every 90 days).

All sign on codes and passwords to Memorial Hermann's computer systems are confidential and are the property of Memorial Hermann Healthcare System. It is a crime, punishable by fine and imprisonment, to reveal passwords to anyone without Memorial Hermann's permission (Texas Penal Code, Section 33.02).

Using another person's sign on code or giving your password to any person will result in termination of your access privileges to Memorial Hermann information systems, and will be reported to the Dean of Student Affairs for disciplinary action.

Entering data into Memorial Hermann's computer systems using another person's code/password is a falsification of records and will result in termination of your access privileges to Memorial Hermann information systems, and will be reported to the Dean of Student Affairs for disciplinary action.

You may also be subject to civil and criminal legal penalties if you violate these security policies.

Student Statement

I acknowledge the information confidentiality policies stated on this form, and I agree to comply fully with these policies.

Printed Name	Signature	School Name	Date

Printed Name	Signature	School Name	Date

(Parent/Legal Guardian if student under 18)