Jefferson Confidentiality Agreement

On behalf of Jefferson Health Corporation and its controlled affiliates including its acute care hospitals and outpatient facilities ("Jefferson")

INSTRUCTIONS:

1. Please **PRINT** or **TYPE** all information.
2. Fill in all requested information.
3. Carefully **read** the Confidentiality Statement.
4. Sign, date and return the completed form.

USER INFORMATION – PLEASE PRINT/TYPE CLEARLY

Student/Faculty Name:

Email Address**:**
(Will be used for notification purposes only)

Phone:

Clinical Program (i.e., Nursing):

Anticipated Start Date Anticipated End Date

SCHOOL Name:

CONFIDENTIALITY STATEMENT AND REQUIRED USER SIGNATURE

SCHOOL Address:

I understand and agree that the information/data I, as a student/faculty, will receive or be exposed to patient health information that is considered ***CONFIDENTIAL.*** Under **NO** circumstances will such information available to me be used, conveyed or discussed by me, unless required in the performance of my duties. I will adhere to all organizational policies that define the confidential information and the protection of that information at Jefferson. I will **not use or disclose PHI that is obtained** via any computing resource or shared with me by my preceptor at Jefferson including, but not limited to; wireless, Internet, **personal** smart devices, unless it is permitted by Privacy laws. I understand that access to PHI is strictly for business purposes. System access will be tracked and monitored for proper use. Furthermore, I agree to the following:

a. I will not make any unauthorized copies of data, which includes photography, and will not save any confidential information to portable media devices (memory sticks, CDs, and other devices);
b. I will not email data to another email account except as expressly provided for in the secure networking environment provided;
c. **I ACKNOWLEDGE AND AGREE THAT I WILL NOT DIVULGE, RELEASE OR SHARE PROTECTED HEALTH INFORMATION TO WHICH I AM PARTY TO without patient authorization.**
d. **Additionally, I acknowledge that I am responsible for ALL PATIENT information that I AM permitted to access and/or view. I understand this access can be monitored at any time;**
e. I agree to notify the Educational Instructor/Help Desk **IMMEDIATELY** if I become aware or suspect that a potential or actual breach of patient information and/or if I have reason to believe that there has been a misuse of data;
f. I agree to secure patient information that is in my possession or at my workstation before leaving my work area to prevent others from accessing confidential information;
g. **I agree to never access data or ask an associate to gain access and/or print documents pertaining to my own PHI, my family members, friends or coworkers, celebrities, public figures, etc. unless the access is necessary to provide education and training or unless this information is needed for me to perform a business related function.**
h. I agree to use the appropriate sources (lab, medical imaging, medical records or patient portal) to request/obtain copies of information contained in my own personal medical record.
i. I will not install or use illegal copies of software on corporate computers;
j. I will not text **ANY** data **or take photos of patients or patient information nor will I post information regarding ANY patient "interesting events" on social media.**
k. **I am aware that any unauthorized access to, alteration or destruction of PHI will result in disciplinary action/termination from this program.**

Third Party Beneficiaries: Jefferson and I agree that any patient whose PHI is disclosed under this agreement is an intended third-party beneficiary to this agreement.
Indemnification: I agree to indemnify and to hold Jefferson harmless from any losses or damage, including reasonable attorney fees incurred in defending itself from a claim by a patient that I breached such patient's right to confidentiality.

Print Name:

Student/Faculty Signature: **Date:**