BOUNDARY COMMUNITY HOSPITAL
STUDENT, JOB SHADOW and/or VOLUNTEER
CONFIDENTIALITY AGREEMENT

I, _____, understand that all Patient Protected Health Information
(Please Print Clearly)
(PHI) is confidential.

This includes:

1. All patient medical and financial information, employee records, financial and operating data of the facility, and any other information of a private or sensitive nature.
2. Confidential information will not be read or discussed by any employee unless it pertains to his/her specific job requirement.
   Examples of inappropriate disclosures include, but are not limited to:
   - Viewing, printing, or transmitting patient information with regard to my personal records, my family records, or any unofficial viewing of any patient information.
   - Staff and student/volunteer discussion or revealing PHI or other confidential information to friends or family members.
   - Staff and student/volunteer discussion or revealing PHI or other confidential information to other staff without a legitimate need to know.
   - Disclosure of a patient's presence in the hospital or other medical facility, without the patient's consent, to any unauthorized party without a legitimate need to know, that may indicate the nature of the illness and jeopardize confidentiality.
3. I agree to abide by the Confidentiality (Overall Hospital Policy), Authorization for Use or Disclosure of Protected Health Information, Access to Patient Data and Information by Hospital Personnel, Email HIPAA Compliance Policy, Need to Know HIPAA Compliance Policy, and all other HIPAA/HITECH policies of Boundary Community Hospital which includes, but is not limited to:
   - Understand that information that I am viewing, printing, or transmitting is confidential information and may not be released to other entities without a signed release from the patient originated from Boundary Community Hospital, with the exception of continued care.
   - Agree to be held accountable for information transmitted/printed and will hold this information in strict confidence.
   - Understand that I will be made accountable for safeguarding and keeping confidential, the computer equipment and the information viewed/printed/transmitted from the computer and will keep it safe from unauthorized use and unauthorized individuals.
   - Agree to not view or print patient's information with regards to my personal records, my family records, or any unofficial viewing of any patient information.
   - Understand that disclosure of PHI or other confidential information to unauthorized persons or unauthorized access to misuse, theft, destroy, alter, or sabotage of such information may result in my immediate dismissal as a student/job shadow/volunteer from Boundary Community Hospital.
   - Agree to conform to any and all Federal or State laws, rules, or regulations. This is intended to include but not limited to HIPAA/HITECH rules.
   - Understand that unauthorized disclosure of PHI or other confidential information by staff and student/volunteer can subject each individual and the hospital to civil and criminal liability.
   - Understand that personal devices are not to be used to view, print, or transmit PHI or confidential information.

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I agree by my acknowledgment signature below, that I understand that PHI*, or other confidential records/data to which I have knowledge and access in the course of my Student, Job Shadow and/or Volunteer placement with Boundary Community Hospital, is to be kept confidential and this practice of privacy and confidentiality is a condition of my Student, Job Shadow, and/or Volunteer placement with the Hospital. This information shall not be disclosed to anyone under any circumstances, except to the extent necessary to fulfill my job requirements. I understand that my duty to maintain confidentiality continues even after the conclusion or my rotations/placement/job shadow and volunteer acitivities at Boundary Community Hospital.

I am familiar with the policies and procedures enforced at Boundary Community Hospital pertaining to the use and disclosure of patient PHI or other confidential information. Approval should first be obtained before any disclosure of PHI or other confidential information not addressed in the policies and procedures of Boundary Community Hospital. I also understand that the unauthorized disclosure of patient PHI and other confidential or proprietary information of Boundary Community Hospital is grounds for disciplinary action.

_____ _____
Student, Job Shadow, and/or Volunteer Acknowledgment Signature Date

Below to be completed by Department Manager or Supervisor:

_____ _____
Supervisor Name (Please Print Clearly) Date

_____ _____
Supervisor Signature Department

☐ Student ☐ Job Shadow ☐ Volunteer
☐ Dates To: _____ From: _____ ☐ Dates To: _____ From: _____ ☐ Start Date: _____

**PHI – Protected Health Information*
Referenced Policies:

- *Confidentiality (Overall Hospital Policy)*
- *Authorization for Use or Disclosure of Protected Health Information*
- *Access to Patient Data and Information by Hospital Personnel*
- *Email HIPAA Compliance Policy*
- *Need to Know HIPAA Compliance Policy*