Division of Health and Human Services

Confidentiality Acknowledgement Form

I, _____, hereby acknowledge that I am bound by federal and state laws regarding patient confidentiality, including where applicable the federal Health Insurance Portability and Accountability Act (HIPAA) and its policies.

I acknowledge that I may work with patients in a class, clinical, practicum, internship, or other type of experiential learning experience where I have access to patient's protected health information. I understand that all medical information is considered confidential and may be protected by HIPAA. In addition, I acknowledge that I have read the confidentiality statements in this handbook and that it is my responsibility to abide by them. I understand that it is therefore unlawful to disclose a patient's confidential health information and medical records without consent. I further acknowledge, that it is my professional responsibility and duty to protect the confidentiality of all patient medical records and protected health information with which I have access to.

My signature confirms that I understand and will abide by patient confidentiality and that I understand the consequences of any inappropriate actions regarding patient confidentiality.

_____ _____

(Student's Printed Name) (Student's CID)

_____ _____

(Student's Signature) (Date Signed)

_____ _____

(Signature of Program Coordinator) (Date Signed)