**Confidentiality Policy**

# HIPAA stands for “**Health Insurance Portability and Accountability Act”** Although this legislative act includes a wide subject range relating to health insurance, a focus of this legislative act is the protection, security, and privacy of patients’ medical records. The University of Scranton has a legal and ethical responsibility to safeguard the privacy of patients and to protect the confidentiality of their health and social information.

Confidentiality of patient information and patient records is of the utmost priority in any health care setting. While participating in clinical education experiences, students will have access to information that must remain confidential. Patients have the right to privacy and confidentiality of their medical information.

* No patient information may be disclosed (verbally or in writing) to unauthorized persons such as friends, family, or other patients.
* Any request by the patient to release medical information must be handles by the appropriate departmental representative. No student will accept responsibility to release patient information.
* You will not discuss patient information in public areas of the facility. This may include therapy offices, if discussion in the office may be overheard by patients in the clinic.
* You will not leave medical charts in unrestricted areas of the facility.
* You will not have mobile devices in the same area as PHI.
* Under no condition may samples of documentation such as evaluations, discharge summaries, or letters to physicians be removed or from the premises of the healthcare facility or photographed on any digital device.
* It is your obligation to keep information confidential continues outside work hours and after clinical experience concludes. Any activity which is violation of this agreement will be reported to the appropriate clinical and academic supervisor. You have attended a training session summarizing HIPAA.

By signing this document, I 1) acknowledge that I have watched the HIPAA video in its entirety and understand the content and my responsibility to keep safe the patient health information (PHI) that I have access to; 2) I understand and agree that I have read and will comply with all of the terms of the above policy; 3) I agree to honor to honor the terms of this agreement.

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Student Name (Please print neatly)

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Student Signature Date