SECURITY AND CONFIDENTIALITY AGREEMENT- Apollo – Youth in Medicine Student Observation Program

Due to the confidential nature of the information maintained by the medical practice, including information contained in patient records, the medical practice has implemented certain requirements to protect records from unauthorized access or disclosure.

I understand that I will come into contact with and be responsible for confidential information of the medical practice. Confidential information which may appear in verbal, written or electronic form, including but not limited to, patient medical information, "protected health information" as defined under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), and the regulations promulgated thereunder at 45 C.F.R. Parts 160 and 164, "patient safety work product" as defined under the Patient Safety and Quality Improvement Act of 2005, Public Law 109-41 (the "Patient Safety Act"), and the regulations promulgated thereunder at 42 C.F.R. Part 3, medical practice financial information, business data, reports, pricing information, projections, records, notes, analyses, studies or information related in any manner to the operations of the medical practice.

AGREEMENT

1. I understand that I am responsible for complying with the HIPAA and the Patient Safety Act policies and procedures and with other HIPAA and Patient Safety Act.

2. I understand that the confidentiality of patient records and protected health information is required by law and that there are statutes or policy reasons specifically mandating the confidentiality of patient information.

3. While shadowing & observing, I will view and have access to confidential information. This means, among other things, that: (a) I will not access confidential information that I have no legitimate need to know. (b) I will not in any way divulge, copy, release, sell, loan, revise, alter or destroy any confidential information except as properly authorized within the scope of my employment. (c) I will not misuse, carelessly handle or fail to safeguard confidential information. **4.** I understand that I have no right or ownership interest in any confidential information.

5. I will not access or use protected health information in a manner not permitted under HIPAA and the regulations promulgated thereunder, or patient safety work product in a manner not consistent with the treatment of such information under the Patient Safety Act and the regulations promulgated thereunder.

6. I will not (i) disclose confidential information outside the medical practice, or inside of the medical practice except to the minimum extent necessary for the performance of health care or organizational duties; or (ii) take confidential information from the premises in paper or electronic form, including, without limitation, removing from the premises a flash drive or other external media on which any such information is stored.

7. If I have a need to print out confidential information, I will print such information only in a manner that allows for my prompt retrieval of the printed material.

8. During any absence from my work area, I will keep any documents containing confidential information to which I have access in secured, hidden locations.

9. I will cooperate with all audits and assessments deemed necessary by the medical practice to review its procedures for maintaining the security and privacy of confidential information.

10. I further understand that the medical practice has incorporated certain privacy requirements into its policies and procedures for access to and treatment of information contained in patient records, including, without limitation, protected health information and patient safety work product, and that it is my responsibility to be familiar with and adhere to such policies and procedures. Any fraudulent application, violation of confidentiality or any violation of the above provisions may result in disciplinary action, including termination of access to system or disciplinary measures that may include termination of my shadowing at the medical practice at the discretion of the medical practice.

11. I understand that violations of confidentiality and privacy laws may result in criminal and/or civil liability or fines.

12. This agreement will be maintained by the medical practice.

13. During the term of shadowing at the medical practice or at any time thereafter, I agree not to disclose any confidential information as described in this Agreement. If for any reason I believe I must release such information, I will first provide immediate notice to the medical practice and give the medical practice a reasonable time in which to respond.

14. Upon cessation of my shadowing, I agree to continue to maintain the confidentiality of any information I learned while an employee and agree to turn over any keys, access cards or any other device that would provide access to the facility or its information.

15. I have read and agree to all of the above as conditions of my shadowing.

16. My signature below indicates my understanding of the above requirements and verifies receipt of a copy of this agreement.

I acknowledge and agree to comply with the obligations and conditions outlined in this agreement. I am also acknowledging the medical practice., has an active on-going program to
review records and transactions for inappropriate access and I understand that inappropriate access to disclosure (intentional or unintentional) of information can result in penalties including disciplinary action, refusal of access to premises, termination of shadowing and/or legal action.

Signed,

Name of Individual Shadowing/Observing (print & signature)

Email Cell phone Date

Parent or Guardian (If individual shadowing is under Age 18) (print & signature)

Email Cell phone Date

Acknowledgement of HIPAA Training (Signature & Date by Individual Shadowing/Observing to be signed AFTER training session)