

STUDENT AND VOLUNTEER CONFIDENTIALITY AGREEMENT

This form is intended to serve as a sample for Michigan attorneys assisting clients with forms for HIPAA compliance. Under HIPAA preemption standards a HIPAA form is not intended to replace a current form being used in compliance with applicable Michigan law. Use of the sample HIPAA forms will require integration of the HIPAA sample form with existing forms currently in use. The attorney also may wish to consult the HIPAA Matrix to determine if any preemption issue under Michigan law needs to be addressed in the form. This form is for educational purposes only and does not constitute, and may not be relied upon, as legal advice.

I will treat all information received by or disclosed to me as a student or volunteer at _____ Hospital as strictly confidential, and will not reveal or discuss confidential information with anyone who does not have a legitimate medical and/or business reason to know the information. I understand that I am permitted to access patient information only to the extent necessary for patient care and to perform my duties. I will not disclose identifying information (e.g. name, date of birth, etc.) if the information can be removed prior to disclosing or using the information.

I will abide by all Hospital's policies and procedures in using Hospital's information. I agree to use all confidential information only as permitted by such policies and procedures. I will not misuse or attempt to alter confidential information in any way.

I understand that Hospital and its providers reserve the right to audit, investigate, monitor, access, review, and report on my use of any confidential information obtained by me related to being a student or volunteer, with or without advance notice to me and with or without my knowledge.

I understand that violation of Hospital policy may subject me to immediate termination of access to the Hospital's facilities, plus civil sanctions and/or criminal penalties.

My signature below acknowledges that I have read and understand this agreement and realize it is a condition of my access to the facilities of and association with Hospital and its providers.

Check one: I am Student Volunteer

Signature: _____ Date: _____

Print Name: _____ Department: _____

School or Volunteer Association (if applicable) _____