

**CONFIDENTIALITY AGREEMENT**

It is the responsibility of all Memorial Hospital of Laramie County d/b/a Cheyenne Regional Medical Center ("HOSPITAL") workforce members, as well as persons present at HOSPITAL for clinical experience purposes such as students, interns, faculty members and other persons participating in the training, to preserve and protect confidential patient, employee, and business information.

The federal Health Insurance Portability and Accountability Act ("HIPAA"), as well as State of Wyoming laws, govern the I release of patients' individually identifiable health information by hospitals and other health care providers and specify that such information may not be disclosed except as authorized by federal and state law or the respective patient or individual pursuant to an authorization in compliance with such laws.

Confidential patient information includes: Any individually identifiable health information in possession or derived from a provider of health care regarding a patient's medical history, mental or physical condition or treatment, as well as the patient's and/or the patient's family members' records, test results, conversations, research records, and financial information. Examples of information that would be protected under **HIPAA** include, but are not limited to:

* Physical, medical, and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
* Patient insurance and billing records;
* Mainframe and department-based computerized patient data and alphanumeric radio pager messages;
* Visual observation of patients receiving medical care or accessing services;
* Verbal information provided by or about a patient; and
* Name, addresses, Social Security numbers, geographic information, birth dates, admission dates, discharge dates.

Confidential employee and business information includes, but is not limited to: Employee home telephone number, address, electronic mail path;

* Spouse or other relative names;
* Social security number or income tax withholding records;
* Information related to evaluation of performance;
* Other such information obtained from HOSPITAL records which, if disclosed, would constitute unwarranted invasion of privacy;
* Disclosure of confidential business information that would cause harm to HOSPITAL.

I understand and acknowledge that:

1. I agree to respect and maintain confidentiality of all discussions, deliberations, patient care records, and any other information generated in connection with individual patient care, risk management, and/or peer review activities.
2. It is my legal and ethical responsibility to protect, and I agree to protect, the privacy, confidentiality, and security of all medical records, proprietary information, and other confidential information related to HOSPITAL and its affiliates, including business, operational, employment, and medical information relating to HOSPITAL's patients, members, employees, and health care providers.
3. I agree to only access or disseminate patient care information in the performance of my assigned duties and where required by or permitted by law, and in a manner which is consistent with officially adopted policies of HOSPITAL or, where no officially adopted policy exists, only with the express approval of HOSPITAL's designated contact person or their designee. I agree to make no voluntary disclosure of any discussions, deliberations, patient care records or any other patient care, peer review, or risk management information, except to persons authorized by law to receive it in the conduct of HOSPITAL affairs.
4. HOSPITAL (administration, Privacy Officer, Security Officer, or Information Technology Department) may perform audits and reviews of patient records in order to identify inappropriate access.
5. My user identification (ID) is recorded when I access electronic records and I am the only one authorized to use my user ID. Use of my user ID is my responsibility whether used by me or anyone else. I will only access the minimum necessary information to satisfy my role or the need as requested by my designated faculty, HOSPTIAL contact person, or their designee.
6. I agree to discuss confidential information only while at HOSP ITAL and only as needed for cooperative education experience related purposes and to not discuss such information outside of HOSPITAL or within heating distance of other people who do not have a need to know about the information.
7. That any and all references to HIV testing, such as any clinical test or laboratory test used to identify HIV, a compone1t of HIV, or antibodies or antigens to HIV, are specifically protected under law and unauthorized release of confidential information may make me subject to legal and/or disciplinary action.
8. That the law protects psychiatric and drug abuse records, and that unauthorized release of such information may make m subject to legal and/or disciplinary action.
9. My obligation to safeguard patient confidentiality continues in perpetuity after completion of my cooperative education experience at HOSPITAL.

I herby acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. In the event of a breach or threatened breach of this Confidentiality Agreement, I acknowledge and agree that HOSPITAL may, as applicable and as it deems appropriate, pursue disciplinary action, up to and including my exclusion from HOSPITAL and the termination of the cooperative education experience.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program/ School/ Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_