GREATER GREEN BAY HEALTH CARE ALLIANCE

Confidentiality Agreement & Acknowledgement of Completion of Orientation Modules

for Students / Advanced Practice Providers / Residents / Faculty Members

Print or type your first and last name:		
Enter the student ID # that identifies you at your school (OPTIONAL):		
(Check one box.) ☐ **Student** ☐ **Advanced Practice Provider** ☐ **Resident** ☐ **Faculty Member**	**School:**	Choose a School
Enter your school's name if 'Other' was selected:		

I understand that during my engagement with the Greater Green Bay Health Care Alliance facility, I may have access to or come in contact with confidential patient, business, practitioner, or provider information. The Health Care Facility defines "confidential information" to include any and all information incorporated in or pertaining to:

1. Patient identities, diagnoses, treatments, or other patient medical or health services.
2. Medical records.
3. Practitioner or provider practice review information.
4. Claims, claim payment and/or reimbursement data and information.
5. Proprietary business information, customer identities, business, or strategic plans.
6. Health Care Facility financial information.
7. Policies, procedures.

This information may be in any form (e.g., oral, written, or electronic) and any format (e.g., individual records, summaries, or consolidated reports, and/or internal or external reports).

Student/Advanced Practice Provider/Resident/Faculty Member agrees to maintain strict confidentiality of any accessed information as described above and disclose it to third parties only if; **a)** authorized in writing by the Health Care Facility and, as appropriate, by the patient, practitioner, or provider involved, and/or **b)** as required by law. This can include, but is not limited to, protecting, and holding confidential patient information unless parties have authorization to that information, accessing only information that is necessary to perform duties as a Student/Advanced Practice Provider/Resident/Faculty Member and discussing a patient's medical information only with those directly involved in that patient's care.

In addition, such information should not be transferred to or from, or stored within, any form of personal technology (e.g. personal computers, laptops, USB drives, cell phones, etc.), nor should it be shared in any form of social media (e.g. Facebook, YouTube, etc.).

I also understand that I am not allowed to access my own patient care record or those of any of my family members or friends/acquaintances without following proper release of information of record viewing procedures.

I understand that I will be subject to, and agree to abide by, the same rules, regulations, policies, procedures, and standards of clinical agencies as are established for the organization's employees in matters related to confidentiality.

The organization may, in its sole discretion, terminate my participation in clinical education at the agency for breach of any of the above. I further understand that I could be subject to legal action, including but not limited to lawsuit for invasion of privacy, or unauthorized access or disclosure of confidential patient health care information. Student/Advanced Practice Provider/Resident/Faculty Member shall, within seven days of discovery of any use, disclosure of contact with any confidential information, report any such use, disclose, or contact to the Health Care Facility.

Student/Advanced Practice Provider/Resident/Faculty Member understands that failure to maintain confidentiality may result in liability to the Health Care Facility as well as its patients, practitioners, and providers, and legal action may be taken. The Student/Advanced Practice Provider/ Resident/Faculty Member further agrees to hold harmless and protect the Health Care Facility against any and all claims for damages resulting from any unauthorized disclosure of such information. Student/Advanced Practice Provider/Resident/Faculty Member understands this obligation survives the termination of Student/Advanced Practice Provider/Resident/Faculty Member's engagement and contractor dealings with Health Care Facility.

I certify that I have completed and understand all the information in the following four GGBHA orientation modules.

1. **HIPAA Privacy & Security**
2. **Infection Prevention**
3. **Professional Expectations in the Workplace**
4. **Safety in the Workplace**

After completing all four orientation modules, the Student/Advanced Practice Provider/ Resident/Faculty Member needs to complete, sign, and submit this *'Confidentiality Agreement & Acknowledgement of Completion of Orientation Modules'* form. By signing below, I certify that I am responsible for understanding the information contained in all the above four orientation modules. Falsifying this statement or failure to comply with any facility's policies will result in disciplinary action that may include expulsion from the facility for the remainder of the clinical or rotation experience.

Enter first & last name.	**Enter date.**
Student/Advanced Practice Provider/Resident/Faculty Member's Printed or Typed Signature	Date
☐ By checking this box, I understand that my typed signature or PDF hand signature constitutes a legal signature.	