HAMILTON HEALTH CARE SYSTEM
CONFIDENTIALITY AND NON-DISCLOSURE STATEMENT

I, _____, a _____student at _____ acknowledge that I have completed training on the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (also known as HIPAA Privacy Rule).

- I understand that all patient information, including billing and financial data, is confidential.
- I agree to keep patient information confidential.
- I agree to use proper disposal methods of patient information and ensure that it is not accessible by the public or any person that doesn't have a need to know.
- I agree to comply with all Privacy Policies and Procedures including those implementing the HIPAA Privacy Rule.
- I understand that if I violate patient confidentiality by using or disclosing patient information improperly, I may be subject to legal action.
- I understand that if I have any questions or concerns about the Privacy Rule and/or the proper use or disclosure of patient information, I should ask my Preceptor, the Director of the Department of which my preceptorship occurs, the Privacy Officer or the Compliance Officer.
- I understand and agree that the Privacy Policies and Procedures will apply to any patient information I have access to even after I terminate my relationship with the Hamilton Health Care System and its affiliates.

Name of University/Medical School_____

Dates of Preceptorship_____

Name of Preceptor_____

_____ _____
Signature of Student Date

_____
Printed name of Student