College of Nursing and Health Professions

Confidentiality Agreement

As a condition of and in consideration of my use, access, and/or disclosure of confidential personal health information, I, _____ understand and agree to the following:

1. I will access, use, and disclose confidential personal health information only as necessary to perform my job functions. This means, among other things, that:
   a) I will only access, use, and disclose confidential personal health information which I have authorization to access, use, and disclose which is required to do my job;

   b) I will not in any way access, use, divulge, copy, release, sell, loan, review, alter, or destroy any confidential personal health information except as properly and clearly authorized within the scope of my job and as in accordance with all applicable University of Southern Indiana and CNHP policies and procedures and with all applicable laws;

   c) I will report to my supervisor or to the appropriate office any individual's or entity's activities that I suspect may compromise the confidentiality of confidential personal health information.

2. I understand that it is my responsibility to be aware of University of Southern Indiana and CNHP policies that specifically address the handling of confidential information and misconduct that warrants immediate termination or dismissal.

3. I understand that any fraudulent application, violation of confidentiality or any violation of the above provisions may result in disciplinary action, including termination of employment or dismissal from my educational program. In addition, federal penalties for privacy violations can result in fines up to $250,000 and prison sentences of up to 10 years.

My signature below indicates that I have read, accept, and agree to abide by all of the terms and conditions of this Agreement and agree to be bound by it.

Signature: _____ Date: _____

Printed Name _____

Department/Program: _____

Check appropriate box:

[ ] student [ ] faculty [ ] staff [ ] student worker [ ] other_____

College of Nursing and Health Professions

CONFIDENTIALITY POLICY

As a member of the University of Southern Indiana College of Nursing and Health Professions (CNHP) workforce you may have access to confidential personal health information. The purpose of this agreement is to help you understand your duty regarding confidential personal health information as described in this policy. Members of the CNHP workforce include but are not limited to faculty, staff, students, and volunteers.

Measures must be taken so that all information received, maintained, or utilized by CNHP and any of its off-site affiliates can only be accessed by authorized users. CNHP has a legal and ethical responsibility to safeguard the privacy and to protect the confidentiality of health information and all other types of confidential information. Health information is confidential information regardless of how it is obtained, stored, utilized, or disclosed.

As a member of the CNHP workforce you are required to conduct yourself in strict conformance to all applicable laws and the University of Southern Indiana and CNHP policies governing confidential information. Your principal obligations in this area are explained below. You are required to read and to abide by these duties. The violation of any of these duties will subject you to disciplinary action, including termination of employment or dismissal from your educational program. In addition, federal penalties for privacy violations can result in fines up to $250,000 and prison sentences of up to 10 years.

As a member of the CNHP workforce, you will likely have access to and use confidential information in any or all of the following categories:

- Client personal health information (such as charts and other paper and electronic records, demographic information, conversations, admission/discharge dates, names of attending healthcare providers, client financial information, etc.);
- Information pertaining to members of the CNHP workforce (such as health records, salaries, employment records, student records, disciplinary actions, etc.);
- University of Southern Indiana and CNHP information (such as financial and statistical records, strategic plans, internal reports, memos, contracts, peer review information, and communications); and
- Third-party information (such as insurance).

As a member of the CNHP workforce you shall only access, use, or disclose confidential personal health information as necessary to perform your job functions.

As a member of the CNHP workforce you shall only access, use, and disclose confidential personal health information which you have authorization to access, use, and disclose as necessary to do your job.

As a member of the CNHP workforce you shall not in any way access, use, divulge, copy, release, sell, loan, review, alter, or destroy any confidential personal health information except as properly and clearly authorized within the scope of your job and as in accordance with all applicable University of Southern Indiana and CNHP policies and procedures and with all applicable laws.

As a member of the CNHP workforce you shall report to your supervisor and to the appropriate office any individual's or entity's activities that you suspect may compromise the confidentiality of confidential personal health information.

UNIVERSITY OF SOUTHERN INDIANA®

College of Nursing and Health Professions

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: CLIENT GIVING CONSENT

Name: _____ Social Security Number _____

Address: _____

Telephone: _____ E-mail: _____

SECTION B: TO THE CLIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

CLIENT IS ENTITLED TO A COPY OF THIS CONSENT AFTER SIGNING.
Include completed Consent in the client's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

UNIVERSITY OF SOUTHERN INDIANA

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COMPLAINT

To the Client:
You have the right to file a complaint with us about our privacy practices or our compliance with our Notice of Privacy Practices, our Privacy Policies and Procedures, or federal or state privacy rules or law. We will not require you to waive any right you may have under federal or state privacy or other law to file your complaint, nor will filing your complaint adversely affect our treatment of you. To exercise this right, please complete, sign and date Sections A and B below, then submit this complaint to us at: awhite@usi.edu.

Contact Office: University of Southern Indiana College of Nursing and Health Professions

Telephone: 812.464.1702

You may, in addition or in the alternative to filing a complaint with us, file a complaint with the United States Department of Health and Human Services. For information on the procedures for doing that, please contact us at the above location.

SECTION A: CLIENT LODGING COMPLAINT

Name: _____ Social Security Number: _____

Address: _____

Telephone: _____E-mail: _____

SECTION B: CLIENT'S COMPLAINT
Please give a concise, plain statement of your complaint:

_____

_____

_____

Please give a concise, plain statement of the resolution you seek for your complaint:

_____

_____

_____

CLIENT'S SIGNATURE

I certify that the statements made in this complaint are true and correct to the best of my information and belief.

Signature: _____Date: _____

If this complaint is lodged by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

_____

Relationship to Client:

_____

YOU ARE ENTITLED TO A COPY OF THIS COMPLAINT.

College of Nursing and Health Professions

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

Client Signature_____

- OR IF SIGNING FOR A MINOR -

Print Name of Minor_____

Parent or guardian of minor signature_____

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

-Workforce Member Unable to Obtain Client Acknowledgment -

Print Name_____

Signature_____

Date_____

College of Nursing and Health Professions

WORKFORCE MEMBER REVIEW OF HIPAA PRIVACY POLICIES AND PROCEDURES

I, _____, have received and reviewed a copy of the University of Southern Indiana College of Nursing and Health Profession's Health Information Privacy Policies and Procedures.

_____
Print Name

_____
Signature

_____
Date