ACKNOWLEDGEMENT RECEIPT

PLEASE SIGN AND RETURN THIS PAGE TO THE STAFFING RESOURCE OFFICE.

I acknowledge receipt of the Orientation Manual for Contract Nurses. I have read and understand the information given.

Print Name:

____

Signature:

____

Date: ______________________________________

Name of agency: ______________________________

ATTESTATION FOR HIPAA TRAINING
COMPLETION OF HIPAA OVERVIEW

I ____have read the material about HIPAA that was given to me. I understand the information about the Privacy and Security Rules and how important it is to patients at the University of Chicago Medical Center. I understand a copy of this signed document will be kept on file as proof that I have completed my HIPAA training.

NAME (PRINT) ____

SIGNATURE ____________________________ **DATE** __________________

ORGANIZATION ____

UCMC CONTACT ________________________________

This page should be maintained by the UCMC department.

THE UNIVERSITY OF CHICAGO MEDICAL CENTER
OFFICE OF MEDICAL CENTER COMPLIANCE

CONFIDENTIALITY AGREEMENT

I understand that I will have access to protected health information (PHI) PHI is anything that identifies or could lead to the identification of a patient or reveals something about the patient's health status.

I understand that any information that I learn about a patient, including the fact that a person is a patient, is confidential under the laws of Illinois and the United States and that information about a patient cannot be disclosed to anyone. I understand that Illinois and federal law provides for possible civil and criminal penalties for disclosure of confidential patient information.

I agree that I will hold PHI in the strictest confidence and will **NOT**:

- Reveal to anyone the name or identity of a patient.
- Repeat to anyone any statements or communications made by or about the patient.
- Reveal to anyone any information that I learn about the patient as a result of reviewing medical records or from discussions with others providing care to the patient.
- Make any copies of, release, sell, loan, review, alter, or destroy any medical records or other medical and/or Confidential Information.
- Give access to medical information to anyone not authorized by UCMC to have access.

I have read this statement. I understand my obligation to maintain patient confidentiality and I agree to follow that obligation. I understand that if I breach my obligation to maintain confidentiality, my access to UCMC information systems will be immediately revoked and I may be subject to disciplinary action.

____
Print Name

______________________________ ______________
Signature **Date**

____
Organization Name

____
Supervisor's Name

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Updated: 12/09