Presence
Mercy Medical Center

HIPAA Privacy Evaluation Questionnaire

Please take a few minutes to complete this questionnaire. Respond by circling the appropriate answer. Please sign your name at the bottom of the questionnaire.

Name (Print) _______________________________ Date______________ Assigned Unit _________
School ________________________ Class #__________________ Instructor ______________________

Your Responsibilities

Yes No Do you understand the importance of respecting the rights of patients to keep their their health information private?

Yes No Do you understand the need to be sensitive to patient concerns when using or disclosing their health related information?

Yes No Do you understand and acknowledge that all patient information is confidential and is property of the organization?

Release of Information

Yes No Do you understand the importance of using or disclosing only the "minimum necessary" health information in order to achieve the intended purpose of the use or disclosure?

Yes No Do you understand the policy concerning the protection of confidential information in public areas?

Yes No Do you understand the importance of being sensitive to the patient's right to privacy by discussing issues related to patient care in the most confidential manner?

Employee Related

Yes No Do you understand that all staff are required to sign a confidentiality agreement annually stating that they understand all policies related to patient privacy?

Yes No Do you understand that you must follow standard procedures to obtain or view your own medical records?

Enforcement

Yes No Do you understand that all Provena Health employees and staff will be held accountable for maintaining the privacy of its patients and the confidentiality of patient information?

Yes No Do you understand that Provena Health does not condone or allow any retaliatory acts towards those who report privacy violations?

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Signature