WEST FLORIDA HOSPITAL

PRIVACY AND CONFIDENTIALITY ACKNOWLEDGEMENT
STUDENTS/FACULTY

I have been asked by West Florida Hospital to reaffirm my commitment made at the time of my visitation/service to protect the confidentiality, privacy and security of health information. I understand that WFH reminds its visitors of their confidentiality obligations on a periodic basis to help ensure compliance, due to the significance of this issue. By my signature below, I acknowledge that I made the commitment set forth below during my presence here at West Florida Hospital.

WFH has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of my visit at WFH, I may come into possession of confidential patient information, even when I may not be directly involved in providing patient services.

I understand that such information must be maintained in the strictest confidence. As a condition of my visit, I hereby agree that, unless directed by my preceptor/West Florida Hospital Representative I will not at any time during or after my experience with WFH disclose any patient information to any person whatsoever or permit any person whatsoever to examine or make copies of any patient reports or other documents prepared by me, coming into my possession, or under my control, or use patient information, other than as necessary in the course of my visit.

When patient information must be discussed with other health care practitioners in the course of my visit, I will use discretion to assure that others who are not involved in the patient's care cannot overhear such conversations.

The following rules must be complied with:

1. Data compiled during the course of visit may not include patient identity or other information, which could identify the patient.
2. Photocopies from the record are not allowed.
3. The record is not to be taken apart or tampered with for any reason.
4. The record is not to be removed from the Health Information Management Department or from the area in which the patient is receiving care.
5. May not use photographic entries as part of their assessment without prior authorization from the patient/legal representative.
6. May not improperly use electronic media, including computers and fax machines.

I understand that violation of this agreement may result in corrective action, up to and including immediate termination of visiting rights, immediate discontinuance of user privileges in Meditech if applicable and possible revocation of any future visiting privileges. Documentation of any disciplinary action will be maintained by the Facility Privacy Official and will be maintained for 6 years as defined by the Privacy Rule.

I have read, understand, and agree to abide by these statements through the duration of my experience at West Florida Hospital. I understand that I must be under the guidance of the hospital preceptor that I was assigned to at all times during my experience.

____

INDIVIDUAL SIGNATURE **DATE**

______________________________ ______________________________

PRINT INDIVIDUAL NAME **SCHOOL AFFILIATION**

____

GUARDIAN SIGNATURE (IF REQUIRED) **DATE**