Lackawanna College
Allied Health Division

Student Confidentiality Agreement

Due to the confidential nature of information, to which I will have access during the routine execution of any duties under the Clinical or Internship requirements I,________ understand, and agree to the following:

1. I agree to maintain as confidential all Protected Health Information as defined by HIPAA or any other state or federal legislation which protects such information, all Protected Health Information which includes but is not limited to, patient health information. I will also maintain as confidential all facility or organizational financial information, other matters of a business or proprietary nature such as information about business operations, prospects, business plans or affairs, financial or otherwise costs, profits, pricing policies, marketing, sales, suppliers, patients, customers, product plans, marketing plans, strategies, or other information related in any other manner to the operations of such Facilities or organizations ("Confidential Information").

2. I understand that as a student/intern of the Lackawanna College __________Program, come in contact with, have access to, and be responsible for Protected Health Information as defined by HIPAA. I agree to keep all information in strict confidence and will not at any time, during my enrollment period, disclose or disseminate any confidential information that I may be exposed to as a result of my association with any patient, facility or organization. I understand I am obligated to maintain patient confidentiality at all times and agree not to disclose any Protected Health Information related to my participation in the Lackawanna College __________________________Allied Health Program to unauthorized people or use such information for personal gain.

3. I understand that all the medical information/records regarding a patient are Protected Health Information. This information will not be given to other individuals unless proper authorization is obtained. I understand that it is not appropriate to discuss a patient's care and treatment in public places (e.g., hallways, elevators, cafeteria, etc.) or with people that are not involved in the case or have no reason to know the information and I agree that I will not do so.

4. I have no need to collect, record, or provide to Lackawanna College any information (name, address, telephone number, cell phone number, social security number, e-mail, and social networking contact or avatar) that may be used to identify a specific individual for the purpose of completing Clinical Internship requirements or documentation.

5. I agree not to disclose any Confidential Information as described in this agreement. I agree to comply with all Hospital Privacy Policies and Procedures, including those implementing the HIPAA Privacy Rule.
6. If for any reason I receive a court order or subpoena requiring me to release Confidential information, I will first provide immediate notice to Lackawanna College and the specific Facility or Organization and give Lackawanna College and the specific Facility or Organization a reasonable time in which to respond.

7. I understand this agreement is not a contract for employment, but the release of any Confidential Information, intentional or unintentional may result in termination of my relationship with a Clinical Site. Violation of confidentiality may result in disciplinary action, including termination from the Lackawanna College Allied Health Division Department of__________without the possibility of re- enrollment. I am also aware that violations of the Privacy and Confidentiality Laws as outlined in HIPAA and this Agreement may result in legal actions against Lackawanna College, the Clinical Site and myself and may further result in criminal and /or civil liability or fines.

8. As a student of Lackawanna College's PTA Program, I understand that if I have any questions or concerns about the Privacy Rule or disclosure of Protected Medical Information, I agree to ask my Program Director or Clinical Supervisor.

9. The above confidentiality considerations have been explained to me, and I was afforded the opportunity to ask questions. I have read and agree to all of the above conditions regarding my status as a student/intern. I understand the importance of privacy and confidentiality of patient and facility and organization related data as outlined in the HIPAA Privacy Rule.

My signature below certifies my understanding and agreement of the above requirements and verifies receipt of a copy of this agreement.

Signature ____________________________________________ Date:________________________