Aspen University
www.aspen.edu
(800) 373-7814

HIPAA CONFIDENTIALITY AGREEMENT (FORM A)

All students and faculty must complete this form. Submit completed form to Project Concert.

Full Name: _____

Check one: ☐ Student ☐ Staff ☐ Faculty

The discussions, uses and disclosures addressed by this agreement mean any written, verbal or electronic communications. I understand that I am never to discuss or review any information regarding a patient at a clinical site unless the discussion or review is part of my assignment to the site. I understand that I am obligated to know and adhere to the privacy policies and procedures of the clinical site to which I am assigned. I acknowledge that medical records, accounting information, patient information and conversations between or among healthcare professionals about patients are confidential under law and this agreement.

I understand that, while in the clinical setting, I may not disclose any information about a patient during the clinical portion of my clinical assignment to anyone other than the medical staff of the clinical site. I understand that I may not remove any record from the clinical site without the written authorization of the site. Additionally, I understand that, before I use or disclose patient information in a learning experience, classroom, case presentation, class assignment or research, I must attempt to exclude as much of the following information as possible:

Names	Certificate/license numbers
Geographical subdivisions smaller than a state	Vehicle identifiers Device identifiers
Dates of birth, admission, discharge, and death	Web locators (URLs)
Telephone numbers and Fax numbers	Internet protocol (IP) addresses
E-mail addresses	Biometric identifiers
Social security numbers	Full face photographs
Medical record numbers	Any other unique identifying number, characteristic, or code
Health plan beneficiary numbers	All ages over 89 years
Account numbers	

Additionally, I acknowledge that any patient information, whether or not it excludes some or all of those identifiers, may only be used or disclosed for health care training and educational purposes at Aspen University, and must otherwise remain confidential. I understand that I must promptly report any violation of the clinical site's privacy policies and procedures, applicable law, or this confidentiality agreement, by me, or an Aspen University student or faculty member to the appropriate Aspen University Clinical Practice Manager, or Program Director.

Finally, I understand that if I violate the privacy policies and procedures of the clinical site, applicable law, or this agreement, I will be subject to disciplinary action. By signing this agreement, I certify that I have read and understand its terms, and will comply with them.

Signature: _____ **Date** _____