WORKPLACE INTERNSHIP
CONFIDENTIALITY LETTER *(RESOURCE 02-04)*

General Confidentiality:

I_____ will be participating in the _____ High School **Workplace Internship** program. I understand that I must follow all rules, regulations, and policies of my host employer and of my school. I further agree to maintain the confidentiality conditions specified by my internship host.

_____ _____

Student Signature Date

Healthcare Facility Confidentiality:

Confidentiality and Privacy of Patient Information

Dear Student,

As a student who is rotating in this health care setting and office practice you have an ethical and legal duty to keep patient infomration confidential. Federal law know as the Health Insurance Portablity and Accountability Act of 1996 (HIPPA) forbids healthcare providers from disclosing paitients' protected healthcare information, except upon written authorization by the patient or as otherwise permitted by the law.

Under the HIPPA Security and Privacy Regulations, hospitals and other healthcare providers are required to have the capacity to determine who is accessing their patients' protected healthcare information and to protect the privacy of that information. Failure to maintain patient confidentiality, accessing patient information without a neeed to do so for your work, or any other violation of policy, may result in disciplinary action against the student, resident or fellow.

Some general guidelines:

- Access patient information only if you need that information to do your work.
- Share or discuss patient information only if it is necessary to do your work and only in appropriate locations.
- If there is electronic health records, never share your identification number or password, and log off computer sessions when you will be away from a workstation.
- Follow the health care system and provider's policies on confidentiality and privacy.
- Ensure confidentiality when you handle all protected healthcare information.

Student Agreement

I have received and reviewed all information that I was given about patient privacy and confidentiality. I understand there are rules regarding the use and disclosure of patient protected healthcare information, and I agree to abide by such rules and keep protected healthcare information confidential. I understand there are both educational and legal punishments if I violate this policy. I recognize that I may be immediately removed and excluded from this program, if I do not comply with this Confidentiality and Privacy Agreement.

_____ _____

Print Name Signature

_____

Date