406 Roy Martin Rd
Suite 9
Gray, TN 37615
423-477-1101 / Fax 423-477-1102

1732 North Eastman Rd
Suite 1A
Kingsport, TN 37664
423-765-1611 / Fax 423-765-1612

HIPPA Confidentiality Statement for Clinical Education Observer

The Federal Health Insurance Portability and Accountability Act (HIPAA) and related laws and regulations were established to preserve the confidentiality of medical and personal information, and to specify that such information may not be disclosed except as authorized by law or unless authorized by the patient. These privacy laws and regulations apply to all Achieve Health and Wellness personnel including students. All students are required to agree to and sign this confidentiality statement.

I _____understand that, as an observer for clinical education purposes at Achieve Health and Wellness, I may see or hear confidential information (such as, but not limited to: medical information, medical history, radiological reports, daily treatment information, etc.) about a patient, verbal discussions about patient care, and electronic communications that include confidential patient information.

I acknowledge that it is my responsibility to respect the privacy and confidentiality of this information. I will not access, use, or disclose any confidential information outside of my educational experience at Achieve Health and Wellness. I understand that I am required to immediately report any information I may have about the unauthorized access, use, or disclosure of confidential information to the Achieve Health and Wellness Clinic Director.

I understand that if I breach any provision of this Agreement, I may be subject to civil and/or criminal liability.

Observer's Name/Student's Name (Please Print):

_____

Observer's Signature/Student's Signature:

_____

Date: _____

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*(If student is under 18 years of age, then parent/guardian signature is needed as well.)

I am the parent/guardian of the student named above and I agree to be responsible for my Child's inappropriate access, use, or disclosure of confidential information during his/her Participation at Achieve Health and Wellness.

Parent/Guardian Name (Please Print):_____

Parent/Guardian Signature: _____ Date: _____