

I, _____ *understand and acknowledge that:*
(Read each item and write your initials in the space provided)

_____ It is my legal and ethical responsibility as an authorized user to preserve and protect the privacy, confidentiality and security of all confidential information relating to WesternU Health, its patients, activities and affiliates, in accordance with the applicable state and federal laws as well as University policy.

_____ I will access, use, or disclose confidential information only in the performance of my training, when required or permitted by law, and disclose information only to those persons who have the legal right to receive that information. When using or disclosing confidential information, I will use or disclose only the minimum information necessary.

_____ I will discuss confidential information for patient-related purposes only with my supervising faculty or other members of the patient's healthcare team. I will not knowingly discuss any confidential information within the hearing of other persons who do not have the legal right to receive the information. I will protect confidential information that is disclosed to me in the course of my clinical rotation with WesternU Health.

_____ Because special protections by law require specific authorization for release of mental health records, drug abuse records, and any and all references to HIV (such as clinical tests, laboratory or otherwise, used to identify HIV, a component of HIV, or antibodies or antigens to HIV) I will defer such authorization for release to my supervising faculty or healthcare provider.

_____ In accordance with WesternU Health HIPAA/HITECH related policies, I understand that my access to all WesternU Health electronic information systems is subject to compliance review by WesternU's Information Technology (IT) Department and the University Compliance Office that includes written reports on whom has accessed a patient's health record(s).

_____ My assigned User ID(s) constitutes my signature and I will be responsible for all entries made under my User ID(s). I agree to always log off of any workstation I was logged into.

_____ It is my responsibility to follow safe computing guidelines. To this end, I agree not to share my User ID or password(s) with any other person. I am responsible for any potential breach of confidentiality resulting from access made to WesternU Health's electronic information systems (including mobile devices) using my user ID and/or password(s). If I believe someone else has used my User ID and/or password(s), I will immediately report my suspicion to the IT department (909-469-5432) and I will immediately change my password.

_____ I also understand that at no time am I to discuss any of the cases, take photographs or videos using my personal phone, or other form of electronic devices, upload any photographs, blog, or tweet about any of the cases I have seen on any form of social media, e.g., Facebook, Twitter, Snap Chat instant messaging; additionally, I will not download, screenshot, or print any documents from the electronic health record (EHR) system, or utilize any other methods to attempt to capture or reproduce any documents from the EHR system.

_____ I also understand that I am responsible for immediately reporting any security breaches to my supervising faculty or healthcare provider.

_____ Under state and federal laws and regulations governing a patient's right to privacy, unlawful or unauthorized access to, or use or disclosure of, patients' confidential information may subject me to: disciplinary action up to and including immediate dismissal from Western University of Health Sciences; civil fines for which I will be personally responsible; and, criminal sanctions.

_____ In the event of a Pandemic or Public Health Emergency, it may be necessary to remotely access a patient's health record from my personal electronic device. In this case, I will be given a different login procedure to use. All HIPAA/HITECH related policies and the information contained herein applies, including not taking photos/videos of the screen. I also understand I must immediately report to the university's IT Department (909-469-5432) if any of the electronic devices I used to access the health record is stolen, lost, or hacked.

I have read, understand, and acknowledge all of the above and my signature below indicates my agreement to comply with this policy.

Student Name (printed) / Student Number

Date

Signature of WesternU Student

College

WesternU Health

Pomona

Date: _____

Department / College: _____

I, _____, have participated in the Western University of Health Sciences WesternU Health Orientation/Recertification. I have received training in the following areas specific to the Center:

- Center Profile and Management
- Public Affairs
- Information and Technology
- Compliance & Privacy
 - Compliance Program
 - Clinical Quality and Compliance
 - Fraud, Waste and Abuse
 - HIPAA/HITECH
 - Red Flag Rule, aka Identity Theft
- Abuse and Domestic Violence
 - Types of abuse
 - Mandated reporter
 - Community Contacts
- Infection Prevention and Control
 - Hand hygiene
 - Communicable disease reporting
 - Standard and Transmission based isolation precautions
- Environment of Care
 - Security and Identification badges
 - Emergency Codes
 - Systems failure and response
 - Emergency Conditions and Responses
 - Earthquake Safety
 - SDS
 - IIPP
 - Radiation Safety

My signature below indicates that I have also completed the required exam and signed the HIPAA/HITECH Compliance Confidentiality statement. I have been instructed that this form and the signed statement will be part of my student/employee file as required by state regulations.

My signature below indicates that I have completed the required WesternU Health orientation process.

Signature of Student/Employee Participant