OCHSNER CLINIC FOUNDATION
CONFIDENTIALITY STATEMENT

REGARDING USER ACCESS:
I UNDERSTAND THAT:

1. The good will of OCF depends upon keeping services and information confidential and that certain legal obligations are attached to this information.
2. I realize that in the course of my employment, I may receive or have access to verbal, written, or electronic media information concerning patients and services performed by OCF even though I do not furnish the services performed for these patients.
3. Patient, employee and business information is privileged and confidential and any unauthorized or inappropriate release, use and/or discussion is a serious matter which may result in corrective action up to and including suspension pending investigation and possibly subsequent termination.
4. My user ID, and the "Password" I choose are my own individual, personal codes for gaining access to electronically stored information. They are the equivalent of my personal signature when performing all computer activities and as such, are legally binding. I will access only the information required in the performance of the job and all information is confidential and to be used only in the performance of my job.
5. I may not use an Ochsner computer to access my own medical records or the records of my family, friends or co-workers even if ordered to do so by the physician.
6. To access my own medical information or the information of a minor child, I must go to the Health Information Management Department and execute an appropriate authorization. I may access records of a family member only by supplying the Health Information Management Department with an appropriate authorization.
7. I may access records of a family member only by supplying the Health Information Management Department with an appropriate authorization. If I share my User ID and Password, use someone else's user ID &/or Password, access my own medical records or otherwise fail to comply with above mentioned OCF's Security Policies, I will be subject to corrective action up to and including suspension pending investigation and possibly subsequent termination.
8. I am responsible for changing my password in the event that my password is lost or its confidentiality has been breached.
9. I am responsible for notifying my immediate supervisor should I undergo a name, department, or job classification change so that my User ID can be kept accurate.

REGARDING CONFIDENTIALITY:

I understand that access of medical information via medical chart (hard or electronic copy) or any other means on any patient, family, friend or myself is against policy. Only when I have a need to know in order to provide direct patient care and by following appropriate protocols is this information to be released. I understand that any violation of this agreement, pending investigation, will result in corrective action up to and including dismissal from Ochsner Clinic Foundation and notification of my Medical Student Program of such action. I agree to abide by this as part of my responsibilities as a Student at Ochsner Clinic Foundation.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA):

The **HIPAA Privacy Rule** prohibits OCF from using or disclosing protected health information (PHI) unless authorized by the patient except in certain circumstances and the **HIPAA Security Rule** requires OCF to safeguard the Confidentiality, Integrity and Availability of electronic protected health information (ePHI) against unauthorized use or disclosure. I agree that I have read the material on both HIPAA Privacy and Security Rules at Ochsner Clinic Foundation.

NAME (please PRINT)	SIGNATURE	DATE

PROGRAM: **The University of Queensland – Ochsner Clinical School**