The Ohio State University Medical Center
Confidentiality Agreement

This form is to be signed by all students and faculty accessing patient information or providing patient care. This may require access to computerized patient record information such as IHIS (Integrated Healthcare Information System); One Source; Pyxis medication access; getting patient care supplies and equipment accessed through Omnicell; bar-coded ID access to specialized units or areas such as Women & Infant and entrance to secure medication and patient care supply areas for individual units.

Students and Faculty must read and sign agreement to the following information:

Pyxis

I understand I will be assigned an OSUMC picture ID card and a password to the Pyxis MEDSTATION System. In combination with my User ID code, this will be my electronic signature for all transactions to the MEDSTATION System, and will be permanently attached to those transactions with a time-stamp and date. These records will be maintained and archived as per the policies of this hospital, and be available for inspection by the Drug Enforcement Agency (DEA) and that State Board of Pharmacy, as is presently done with my handwritten signature for controlled substance records. **To maintain the integrity of my electronic signature, I must not give my ID card or password to any other individual.**

Computer Systems-Patient Confidentiality Statements

I understand that computer systems contain confidential patient care; business, financial and/or employee information and that access will be monitored. I agree to access information only as necessary to accomplish my job-related duties. I will not discuss confidential information in public areas such as elevators, hallways, or the cafeteria. I understand I am responsible for any printed reports I use and will assure they are either filed appropriately or shredded. I understand that my password is for my official use only. I agree not to share my password or allow another user to access or alter information from any computer after I have logged on. I will not post, disclose, or otherwise distribute my password. I understand that any violation of this agreement may result in immediate termination of my computer access privileges, in addition to appropriate disciplinary action.

Medical Records-Patient Confidentiality

I understand that the information collected and maintained on patients of The Ohio State University Medical Center (and its affiliates) is confidential. I agree that all information made available to me will be held confidential and that I will not divulge any information of a patient-identifiable nature. Information abstracted from medical records, indexes, data bases, etc., will not identify the patient. Any reports, documents, case studies, or publications resulting from my review of this information will not identify either patients or The Ohio State University Medical Center and its affiliates.
Further, I understand that the medical records, indexes, etc., that I have been given access to may not, under any circumstances, be removed from the Medical Center for any purpose. These records and documents may not be photocopied by any method.

_____

Student Name (please print full legal name)

_____

Student Signature **Date**

Complete form, sign, and send to:
College of Nursing Student Affairs
106 Newton hall
1585 Neil Avenue
Columbus OH 43210-1289

FAX: (614) 292-9399

Email as scanned attachment to: CON-studentaffairs@osu.edu

- Office Use Only - Please do not write below this line

Faculty Name Faculty Signature

College of Nursing
School/College

Undergraduate
Student Level

_____
Hospital Badge Number *(leave blank)*