WASHINGTON STATE UNIVERSITY | Elson S. Floyd College of Medicine

HIPAA Student Confidentiality Agreement

I acknowledge that I have read, understand and agree to comply with the Washington State University Elson S. Floyd College of Medicine process of de-identification regarding protected health information (PHI) in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as described below.

I understand that all protected health information such as patients' medical records (i.e., admitting/discharge records, labs, imaging), confidential information (i.e., social security number, financial information, card holder data), and other data to which I have knowledge of and/or access to as a result of being a student in a health science program will be kept confidential. I agree not to disclose this information under any circumstances including to family, friends, and/or social media sites.

I acknowledge that I must de-identify all patient data that I obtain in a clinical setting so I can use it as part of my participation in a health science program at WSU College of Medicine including any downloading of it. De-identification specifically requires the removal of identifiers of the patient or of relatives, employers, or household members of the patient. More specifically, the following identifiers must be removed:

(A) Names	(J) Account numbers
(B) All geographical subdivisions (street address, city county, ZIP code	(K) Certificate/license numbers
(C) All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age	(L) Vehicle identifiers and serial numbers, including license plates
(D) Telephone numbers	(M) Device identifiers and serial numbers
(E) Fax numbers	(N) Web universal resource locators (URLS)
(F) Email addresses	(O) Internet Protocol (IP) addresses
(G) Social security numbers	(P) Biometric identifiers, including finger and voice prints

(H) Medical record numbers	(Q) Full-face photographs/radiography and any comparable images
(I) Health plan beneficiary numbers	(R) Any other unique identifying number, characteristic, or code
And, the covered entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.	

I understand that I cannot remove any confidential data/information, including PHI from a clinical setting (i.e., hospital, emergency care site, physician office, clinic, etc.) where I may be assigned as part of my training at College of Medicine. I also agree to become knowledgeable of the assigned clinical setting privacy/security policies and follow them. I agree that any clinical data that I have access to and may be needed to demonstrate clinical competency as part of my course requirements will be de-identified. I understand that it is never acceptable to disclose any confidential information, including posting such information on social media (i.e., Facebook, Twitter) and/or public settings. I also agree not to send confidential information, including PHI, to my private email account or download it on my personal computer and/or mobile device. I understand that if I breach this Confidentiality Agreement, disciplinary action may result.

Printed Name _____

Signature of Student _____

Date_____