Faculty/Staff Orientation and Confidentiality Statement

Please fill out this form in its entirety, print and sign, then submit to Orientation Coordinator at Unified Clinics, Third Floor; OR email signed and scanned copy to the Unified Clinics Orientation Coordinator: uc-medicalrecords@wmich.edu. TYPED SIGNATURES WILL NOT BE ACCEPTED.

Name: ____

Clinic (ex: Speech, OT, BHS): ____

Phone:______________________________Email:_______________________________

Western Michigan University HIPAA Agreement and Acknowledgment form

I, ______________________________, acknowledge that I have received training regarding the Unified Clinics policies and procedures concerning Protected Health Information (PHI) use, disclosure, storage and destruction, as well as the policy regarding sanctions for violations of the Privacy Rule and these policies as required by HIPAA. In consideration of my employment/ compensation or clinical work from the Unified Clinics, I hereby agree that I will not at any time – either during my employment/association with the Unified Clinics or after my employment/ association ends – use, access, or disclose PHI to any person or entity, internally or externally, except as is required and permitted in the course of my duties and responsibilities with the Unified Clinics, as set forth in the Unified Clinics privacy policies and procedures as permitted under HIPAA.

I understand that this obligation extends to any PHI that I may acquire during the course of my employment or association with the Unified Clinics, whether in oral, written, or electronic form and regardless of the manner in which access was obtained. I understand and acknowledge my responsibility to apply the Unified Clinics policies and procedures during the course of my employment or association. I also understand that unauthorized use or disclosure of PHI will result in disciplinary action up to and including the termination of employment, or association with the Unified Clinics and the imposition of civil penalties and criminal penalties under applicable federal and state law, as well as professional disciplinary action as appropriate. I understand that this obligation will survive the termination of my employment or end of my association with the Unified Clinics, regardless of the reason of such termination.

I understand that I will not be issued a Unified Clinics badge or authorized to perform clinical duties unless this form has been submitted and approved.

Signature:____ Date:__________

Orientation Coordinator Signature:______________________________ Date: __________

This agreement form is valid from one year from the signed date above, at which time, recertification will be necessary if the student is still participating in clinic services at the Unified Clinics, or through offsite fieldwork as required by the Unified Clinics or clinical department.