Confidentiality Agreement

DISCLOSURE OF PATIENT/PROVIDER INFORMATION

I recognize that the service provided by Henry Ford Health System for its patients are private and confidential; that to enable the Hospital to perform those services, patients must furnish information to the Hospital with the understanding that it will be kept confidential and used only by authorized persons as necessary in providing these services; that the good will of the Hospital depends upon keeping services and information confidential; that certain legal obligations are attached to this information; and that by reason of my duties as a student/instructor or in the course of my studies, I may receive or have access to verbal, written, or electronic medical information concerning patient and services performed by the Hospital even though I do not furnish the services performed for those patients.

I recognize that by reason of my duties during my student or instructor status I may receive or have access to verbal, written or electronic media information concerning employees of Henry Ford Health System and the facilities themselves. This information may include, but is not limited to, salaries, benefits, personnel information, financial information, and private healthcare information.

I hereby agree, except as directed by the Hospital or by legal process, I will not at any time during or after my student status or instructor status or in doing my duties as a student/instructor at the Hospital, disclose any information whatsoever to any person or entity by any means, or permit any such person or entity to examine **or make copies** of any reports or other documents prepared by me, coming in to my possession or performed by the Hospital, including but not limited to census reports, demographic information, diagnosis or treatment information, summaries of such information, any business or consultation report, planning documents, financial information of any kind, business reports, correspondence, vendor/supplier information, contract price or terms. I agree that I will not attempt to use any such information for my own advantage.

I recognize that the unauthorized disclosure of information by me may violate State or Federal laws and do irreparable injury to the Hospital or to the patient or employee and that the unauthorized release of information will result in disciplinary action, including severing of the student/instructor/ clinical site relationship and/or legal action being taken against me.

_____ _____

Faculty/Student Signature Date

_____

Printed Name

_____

Nursing School Name