ATTESTATION FOR HIPAA TRAINING
COMPLETION OF HIPAA OVERVIEW

I _____ have read the material about HIPAA that was given to me. I understand the information about the Privacy and Security Rules and how important it is to patients at the University of Chicago Medical Center. I understand a copy of this signed document will be kept on file as proof that I have completed my HIPAA training.

NAME (PRINT) _____

SIGNATURE _____ **DATE** _____

ORGANIZATION _____

UCMC CONTACT _____

This page should be maintained by the UCMC department.

THE UNIVERSITY OF CHICAGO MEDICAL CENTER
OFFICE OF MEDICAL CENTER COMPLIANCE

CONFIDENTIALITY AGREEMENT

I understand that I will have access to protected health information (PHI) PHI is anything that identifies or could lead to the identification of a patient or reveals something about the patient's health status.

I understand that any information that I learn about a patient, including the fact that a person is a patient, is confidential under the laws of Illinois and the United States and that information about a patient cannot be disclosed to anyone. I understand that Illinois and federal law provides for possible civil and criminal penalties for disclosure of confidential patient information.

I agree that I will hold PHI in the strictest confidence and will **NOT**:

- Reveal to anyone the name or identity of a patient.
- Repeat to anyone any statements or communications made by or about the patient.
- Reveal to anyone any information that I learn about the patient as a result of reviewing medical records or from discussions with others providing care to the patient.
- Make any copies of, release, sell, loan, review, alter, or destroy any medical records or other medical and/or Confidential Information.
- Give access to medical information to anyone not authorized by UCMC to have access.

I have read this statement. I understand my obligation to maintain patient confidentiality and I agree to follow that obligation. I understand that if I breach my obligation to maintain confidentiality, my access to UCMC information systems will be immediately revoked and I may be subject to disciplinary action.

_____

Print Name

_____ _____

Signature **Date**

_____

Organization Name

_____

Supervisor's Name

This page should be maintained by the UCMC department.

FINGERNAIL HYGIENE POLICY

Nails must be neat, rounded rather than pointed. They must be short enough to prevent scratching the patients when providing care. No artificial nails or overlay wraps (silk) are allowed.

Traveler Signature_____

Print Name_____

The University of Chicago Medical Center
ACKNOWLEDGEMENT OF RECEIPT OF FALL PREVENTION POLICY

I acknowledge that I have received, read and understand The University of Chicago Medical Center's Falls Prevention Policy (PC149 Review date: April 2017)

_____

Print Name

_____ _____

Signature Date

_____

Organization Name