Department of Emergency Medicine
UofL Shadowing Agreement

First Name: _____ Last Name:_____

Preferred Name: _____

Current Level of Education: _____ Name of School:_____

Major, or planned profession: _____

Phone Number: _____ E-mail address: _____

Department of Emergency Medicine, UofL Observation Agreement

University of Louisville (UOFL) policy and federal regulations protect the privacy of our patients' health information. The Health Insurance Portability and Accountability Act (HIPAA) is a set of federal rules that defines what information is protected, sets limits on how that information may be used or shared, and provides patients with certain rights regarding their information. UOFL has its own policies that reflect these regulations as well as best ethical standards.

These rules protect information that is collected or maintained, (verbally, in paper, or electronic format) that can be linked back to an individual patient and is related to his or her health, the provision of health care services, or the payment for health care services. This includes, but is not limited to, clinical information, billing and financial information, and demographic/scheduling information. **Even the fact that an individual has received care at UofL is protected by UofL policy and federal regulations.**

UofL policy and HIPAA regulations limit the use or sharing of protected patient information to the following purposes: providing treatment, obtaining payment for services, certain health care administrative functions and when required or permitted by law. Any other use or disclosure of protected information requires written authorization from the patient. For all uses or disclosures other than treatment, only the minimum amount of information necessary will be shared on a need to basis. The Notice of Privacy Practices describes to patients how we may use or disclose their health information and patient rights regarding their protected health information.

CONFIDENTIALITY AGREEMENT FOR VISITORS IN CLINICAL AREAS

As a visitor at University of Louisville, you are required to conduct yourself in strict conformance to all applicable laws and UOFL policies governing confidential information. **Simply by being in the Medical Center, you may encounter confidential patient information.** Care is often coordinated in semi-public environments where there is the risk that patient information may be heard or viewed by individuals not directly involved in the patient's care. UofL has polices intended to limit the risks of such incidental disclosures of patient information.

You may see or hear information related to UofL patients (such as charts and other paper and electronic records, demographic information, conversations, admission/discharge dates, names of attending physicians, patient financial information, etc.). **Any patient information you see or hear, either incidentally or by attending rounds, must be kept confidential. By signing below, you are agreeing to abide by UofL policies regarding confidentiality of patient health information.**

Department of Emergency Medicine
UofL Shadowing Agreement

As a condition of and in consideration of, my use, access, and/or disclosure of confidential information, I, _____ understand and agree to the following:

- I will access, use, and disclose confidential information only as permitted by UofL hosts. This means that I will only access, use, and disclose confidential information that I have been given authorization to access, use, and disclose.
- I understand that any fraudulent application, violation of confidentiality or any violation of the above provisions will result in the termination of my privilege to observe and participate in rounds in clinical areas and I may be subject to legal liability as well.
- I have successfully completed HIPAA training.
- I have received and reviewed the current UofL HIPAA Privacy Guidance document.
- My signature below indicates that I have read, accept, and agree to abide by all of the terms and conditions of this Agreement and agree to be bound by it.

Signature: _____ Date: _____