PULLMAN REGIONAL HOSPITAL

Volunteer Confidentiality Statement

All patient Protected Information (PHI- which includes patient medical and financial information), employee records, financial and operating data of Pullman Regional Hospital, and any other information of a private or sensitive nature is considered confidential.

Confidential information shall not be used or disclosed unless specific permission to do so has been obtained and granted by the privacy officer or designee. Applicable federal and state laws shall be followed to seek patient permission for any use or disclosure of PHI. Examples of inappropriate disclosures include:

- Discussing or revealing confidential information to friends or family members
- Discussing or revealing confidential information to other coworkers or employees without a legitimate need to know
- The disclosure of a patient's presence in the office, hospital, or other medical facility, without the patient's consent, to an unauthorized party without a legitimate need to know and that may indicate the nature of the illness and jeopardize confidentiality
- Using patient information for marketing purposes without express permission from the Pullman Regional Hospital and patient

The unauthorized disclosure of confidential information can subject an individual and the individual's employer to liability. Disclosure of confidential information to unauthorized persons, or unauthorized access to, or misuse, theft, destruction, alteration, or sabotage of such information, may result in your immediate removal from the premises and/or revocation of current and future volunteering privileges of the individual and/or company, and may lead to legal action and/or a duty for you to mitigate damages.

Confidentiality Agreement:

I hereby acknowledge, by my signature below, that I have viewed the HIPAA training video provided by Pullman Regional Hospital. I understand that patient PHI and other confidential or proprietary information of Pullman Regional Hospital which I may see or hear or otherwise gain knowledge of in the course of my volunteer duties with Pullman Regional Hospital is to be kept confidential, and this confidentiality is a condition of my privilege to volunteer with Pullman Regional Hospital. This information shall not be used or disclosed to anyone unless specifically authorized by Pullman Regional Hospital. The unauthorized use or disclosure of patient PHI is possible grounds for: immediate removal from the premises; revocation of all future volunteering privileges; legal action; and/or a duty to mitigate damages.

_____ _____

Date Signature

_____

Print Name

PULLMAN REGIONAL HOSPITAL

JOB SHADOW
PERSONAL INFORMATON FORM

Date_____

Department and Clinician/Employee providing shadow experience: _____

_____

(Department) (Clinician/Employee)

GENERAL INFORMATION FOR JOB SHADOW APPLICANT

Name_____
Last First MI

Local Address_____
Street City State Zip

Permanent Address_____
Street City State Zip

Phone Number_____ _____ _____
Home Cell e-mail address

Date of Birth_____
Month Day Year

EDUCATION

High School_____

College_____

Major Area of Study_____

EMERGENCY CONTACT

_____
Name Relationship Phone

_____ _____
Job Shadow Applicant signature Date

_____ _____
Clinician/Employee (providing job shadow) signature Date

revised 09/14