



Student/Trainee Confidentiality Statement

A federal law named “HIPAA” (Health Insurance Portability and Accountability Act) defines “protected health information” and sets standards for health care providers to protect that information. The law also defines stiff penalties (fines and even imprisonment) for violating those privacy provisions. Various Wisconsin state laws also protect the privacy of patient information.

Protected information is defined as any information, whether oral or recorded in any form or medium, which relates to:

- The past, present or future physical or mental health or condition of an individual;
- The provision of health care to an individual; or
- The past, present or future payment for the provision of health care to an individual; and
- There is a reasonable basis to believe the information can be used to identify the individual.

Protected health information includes, but is not limited to, demographic, insurance, billing, medical or other information collected, created, or received in the course of providing health care to an individual.

As a student or trainee, I acknowledge and agree that when I am being trained on health care procedures, I am subject to the requirements of state and federal privacy laws. As a health care student/trainee, I may access protected health information in the course of my training at a facility of Aurora Health Care, Inc. (“Aurora”). I agree that any protected health information to which I have access at an Aurora facility cannot be used for a purpose other than my training, and cannot be disclosed by for any reason. I am knowledgeable regarding the requirements of laws related to the use and disclosure of such information. In addition, I realize I may have incidental access to the protected health information of other Aurora patients. “Incidental” means that access to information is not required, but may occur as a result of the treatment services that I may provide. I agree that I will not use or disclose any information that I obtain incidentally for any purpose.

I am required to follow these rules, and my signature below attests that I understand and agree to abide by them.

Signature

Date

Name (Please print.)

Company/School

Aurora Health Care Representative

Aurora Facility/Entity