**University of Oklahoma**

**Confidentiality Agreement**

**Volunteers/Visitors/Trainees**

 I understand that I may, during the course of my visit or volunteer/trainee service to the University of Oklahoma, College/ Department of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hear, see, and/or otherwise come into contact with patient information of a medical and/or personal nature or student education/treatment records, (“Information”). Therefore, I, the undersigned, do hereby affirm that I will:

1. Protect and safeguard this Information from any oral and/or written disclosure and not disclose any Information to third parties, including family members, students, faculty members, or other health care providers.
2. Not view or copy patient schedules, procedure schedules, patient medical records, or similar documents, except as specifically allowed by the University. I may not use any Information in presentations, reports, or publications of any kind without the University’s prior written approval.
3. Not release Information from any medical record source to any unauthorized person while I am at the University or thereafter, without the University’s prior written approval.
4. Restrict my own access to Information, if any, to that which is essential for and minimally necessary to the proper completion of my responsibilities while visiting or volunteering at the University.
5. Complete any training required by the University, including but not limited to HIPAA Privacy and Security training.
6. Not bring to the University the confidential information of any other entity or person or store such in or on University property.
7. Not put any Information on my personally-owned devices or on any unencrypted devices or cloud storage. I will not remove any patient information in any format from the University for any reason.

I understand that all University policies on confidentiality and this Agreement apply equally to Information stored on paper records, electronically, or on any other media.

 Finally, I understand that any misuse of Information from a patient’s medical record or elsewhere, or any violation of the principles of patient confidentiality, whether intentional or due to neglect on my part, will be grounds for immediate exclusion from future participation in programs sponsored or held by the University.

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| **Participant’s Name:** |       |
|  | (Please Print Full Name) |  |
| Signature: |  | Date: |       |
| Participant (or legal representative\* if participant is a minor) |  |
|  |  |
| Date(s) intended to be on Campus: |  |
|  |  |  |  |
| Witness: |       |       |       |
| College/Department Representative | Phone | Date |

\*May be requested to show proof of representative status.