MARICOPA COUNTY COMMUNITY COLLEGE DISTRICT
2411 West 14th Street, Tempe, AZ 85281-6942

FACULTY/STAFF/STUDENT CONFIDENTIALITY AGREEMENT

for MCCCD Health Care Integrated Educational System Clinical Training

Name (Print) : _____ **Check One:** ☐ **Student** ☐ **Staff** ☐ **Faculty**

College: _____ **Health Care Program:** _____

The discussions, uses, and disclosures addressed by this agreement mean any written, verbal, or electronic communications.

I understand that I am never to discuss or review any information regarding a patient at a clinical site unless the discussion or review is part of my assignment to the site. I understand that I am obligated to know and adhere to the privacy policies and procedures of the clinical site to which I am assigned. I acknowledge that medical records, accounting information, patient information, and conversations between or among healthcare professionals about patients are confidential under law and this agreement.

I understand that, while in the clinical setting, I may not disclose any information about a patient during the clinical portion of my clinical assignment to anyone other than the medical nursing staff of the clinical site.

I understand that I may not remove any record from the clinical site without the written authorization of the site. Additionally, I understand that, before I use or disclose patient information in a learning experience, classroom, case presentation, class assignment, or research, I must attempt to exclude as much of the following information as possible:

- Names
- Geographical subdivisions smaller than a state
- Dates of birth, admission, discharge, and death
- Telephone numbers
- Fax numbers
- E-mail addresses
- Social security numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers
- Device identifiers
- Web locators (URLs)
- Internet protocol addresses
- Biometric identifiers
- Full face photographs
- Any other unique identifying number, characteristic, or code
- All ages over 89 years

Additionally, I acknowledge that any patient information, whether or not it excludes some or all of those identifiers, may only be used or disclosed for health care training and educational purposes at MCCCD, and must otherwise remain confidential.

I understand that I must promptly report any violation of the clinical site's privacy policies and procedures, applicable law, or this confidentiality agreement, by me, or an MCCCD student or faculty member to the appropriate MCCCD clinical coordinator or program director.

Finally, I understand that, if I violate the privacy policies and procedures of the clinical site, applicable law, or this agreement, I will be subject to disciplinary action.

By signing this agreement, I certify that I have read and understand its terms, and will comply with them.

Signed: _____

Date: _____