

Community Hospital - Fairfax

Confidentiality Statement

Student Observer Program

Community Hospital is proud to welcome you to our facility. By signing this, you are agreeing to hold the protected health information as defined by HIPAA privacy standards on patients and medical staff members in confidence. Further, you understand that any violation of this confidentiality will result in your immediate disqualification from working in this facility.

I understand and agree to adhere to the above statement.

Student Signature

Date

PHI includes:

Name	Medical record number
Address	Health Plan beneficiary number
Names of relatives	Account number
Name of employees	Certificate/license number
Birth date	Any vehicle or other device serial number
Telephone Numbers	Web Universal Resource Locator (URL)
FAX numbers	Internet Protocol (IP) address number
Electronic Mail Addresses	Finger or voice prints
Social Security numbers	Photographic images and

Any other unique identifying number, characteristic, or code that the covered entity has reason to believe may be available to an anticipated recipient of the information.

Approved by the HIPAA Committee, September 25, 2002