VISITING CLINICIAN AND HEALTHCARE PROFESSIONAL CONFIDENTIALITY AGREEMENT

The UT Medicine _____ Clinic, UT Health San Antonio permits visiting clinicians and healthcare professionals from other institutions to observe procedures performed in the _____ by UT Medicine clinicians and laboratory staff at UT Medicine. Federal and state laws, accreditation standards, and professional ethics require that all health care providers maintain and protect the confidentiality of patient information to the greatest extent possible. The purpose of this agreement is to establish the following understanding between UT Medicine and the visiting clinician/healthcare professional regarding confidentiality of patient information.

I understand that I have been permitted to observe in the _____ on [***insert dates mm/dd/yyyy***].

I understand that during the course of my observation, I may come in contact with the individually identifiable information of UT Medicine's patients. Individually identifiable information means any information that identifies a patient, including demographic, financial, and medical, that is created by a health care provider or health plan that relates to the past, present or future condition, treatment, or payment of the individual.

I understand that individually identifiable information includes all patient identifiable information in any medium, including, but not limited to oral, written, hard copy, and electronic (whether retrieved on screen or contained on a computer disc or portable data storage).

I understand that I am not authorized to enter into, copy from, or otherwise manipulate UT Medicine's electronic medical record.

I understand that individually identifiable information is to be held in strict confidence and I agree that I will not:

1. Share any patient information with any person or permit any person to examine documents I come into contact with or which I create except as allowed within my duties or by patient authorization.
2. Review any individually identifiable information not directly relevant to my observation.
3. Discuss any individually identifiable information with anyone who does not have a legitimate, professional need-to-know the information.
4. Disclose the information to any person or organization outside UT Medicine without proper, written authorization from the patient.

I understand that the obligations outlined above will continue after my observation.

I understand any patient information in my possession will be returned to UT Medicine after my affiliation unless there is written authorization from the patient.

My signature acknowledges that I have read and agree to the terms and conditions of this agreement. I understand that violation of any of the above may lead to civil and/or criminal penalties pursuant to federal and state regulations.

_____ _____

Signature of Visiting Clinician/Healthcare Professional Date

_____ _____

UT Medicine Staff Date