Confidentiality Statement for [insert hospital name] Advisors

As a patient and family advisor at [insert hospital name], you will be trusted with information about our hospital and the patients we serve. This may include information about patient care experiences, diagnoses, hospital quality and safety, and other sensitive information. It may also include **protected health information** about patients.

Protected health information includes any information about a patient's visit at [insert hospital name]. This information includes, but is not limited to, a patient's name, address, phone number, date of birth, financial information, diagnosis, and treatment.

A Federal law called HIPAA (pronounced "hip-uh") explains what health care providers must do to safeguard protected health information. HIPAA stands for the Health Insurance Portability and Accountability Act. The law requires us to define the minimum necessary information to which employees, volunteers, contracted agencies, and other individuals can have access.

As a patient and family advisor, you may have access to protected health information about our patients. It is important for you to know that protected health information can only be used and disclosed as permitted by law. This means that protected health information cannot be shared outside the hospital or health care facility, and it cannot be shared in any written, verbal, or email communications with friends or family unless specifically permitted by law.

The easiest way to remember what this law means is the saying, "What you hear or see here must remain here." We require your cooperation in following these rules.

Please sign below to let us know that you have reviewed this information, understand it, and agree to it. Signing your name means that you have read and understood the information above, that you have had a chance to ask questions, and that you agree not to share protected health information outside the hospital or health care facility in any written, verbal, or email communications.

Name (please print) _____

Signature _____

Date _____

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov