Area Hearing & Speech Clinic

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HIPAA COMPLIANCE FORM FOR INTERNSHIP STUDENTS AND RESIDENT STUDENTS:

Area Hearing and Speech Clinic, INC. takes the privacy of its patients extremely seriously. It is expected that our internship students, as well as our residential students, do the same. For the following, please initial, sign, and date in the lined areas, assuring Area Hearing and Speech Clinic, INC. that you, as the student, understand what is expected of you during your time at the clinic.

1. I understand that no patient files are allowed outside of the confines of Area Hearing and Speech Clinic, INC., at any time. I: _____
2. I understand that the discussion of patient names, dates of birth, and case files cannot be discussed outside of the confines of Area Hearing and Speech Clinic, INC. I: _____
3. I understand that the privacy of our patients is required to stay in the clinical settings at all times. I: _____
4. I understand that all business ventures by Area Hearing and Speech Clinic, INC., and business ventures discussed are required to stay within the confines of the clinic only. I: _____
5. I understand that if I do not follow the policies set in place by Area Hearing and Speech Clinic, INC., it will, in return, result in my dismissal from the internship program. I: _____

The policies set in place are for the protection of our patients as well as the clinic. Adhering to these policies is critical in providing the best care possible for our patients at Area Hearing and Speech Clinic, INC. As an intern at Area Hearing and Speech Clinic, INC., I hereby agree to the terms and conditions of these privacy policies and attest that I have read them and understand the critical nature of privacy held by Area Hearing and Speech Clinic, INC.

_____ _____

Intern Student or Resident Signature Date