OhioHealth

Observership Application Form

GENERAL INFORMATION		
Last Name:	First Name:	Middle Initial:
Date of Birth:	Email Address:	
Mailing Address:		
City:	State, ZIP:	Phone Number:
School/Program (or n/a):		
Undergraduate or Graduate (or n/a):		

OBSERVERSHIP INFORMATION	
Department of Observation:	
Provider to be Observed:	
Dates of Observation:	
Total Number of Hours:	

NOTIFY IN CASE OF EMERGENCY	
Name:	Relationship:
Home Phone:	Cell/Work Phone:

Signature:	Today's Date:

Protecting the Information Assets of OhioHealth

CONFIDENTIALITY STATEMENT OF UNDERSTANDING

(signed by associates, residents, students, and contractors)

This statement summarizes the responsibilities and obligations of all persons who use, create or receive confidential information belonging to OhioHealth patients and to OhioHealth care sites as set out in the Corporate SPP Confidentiality Agreement (REG-124-0H). It is the responsibility of all persons granted access to confidential information to protect the privacy of patient and healthcare information and to make use of that information only to the extent authorized and necessary to provide patient care and/or to *perform* a *proper business, Medical Staff or educational function.*

"I _____(name) recognize and acknowledge that all patient-identifiable Information and OhioHealth business information is confidential. By reason of my duties, I may comeinto possession of this confidential information even though I may not take any direct part in furnishing thepatient services or developing the business information. I agree that I will not, at any time during or after my employment or term of service, improperly use or disclose any confidential information to any person/entity or permit any unauthorized person/entity to examine or make copies of any reports, documents, or on-line information that comes into my possession. Additionally, as this confidential information is availableonly on a need-to-know basis, I will not access confidential information without authorization andwill do so only when required to do so.

I recognize that the unauthorized disclosure of confidential information is totally prohibited.

I also recognize that the disclosure of or sharing of passwords, access codes, key cards, or other mechanisms assigned to me is prohibited and that I am accountable for themand for any improper access to information gained with these privileges. My access privileges are the equivalent of my legal signature. I shall take all reasonable and necessary steps to protect my access privileges. I acknowledge that I am responsible for all actions taken using those privileges. If I have reason to believe that the confidentiality of my access privileges has been broken, I shall immediately notify my employer or the OhioHealth Security Officer. Where patient information is involved I shall immediately notify the OhioHealth Privacy Officer.

I understand that if I violate any of the above statements I may lose my access privileges immediately and that any violation may result in corrective action from my employer, sponsoring organization, or academic institution in the interest of the patient and healthcare organization."

If employed in a physician's private practice:
"I also acknowledge that violation of any of the above statements will reflect upon my employer and will result in corrective action by Medical Staff Services / Medical Executive Committee for my employer as well."

Internet User Agreement

Purpose

Patient and healthcare business information are important assets of OhioHealth. It is essential that associates provide for the protection of this information. This agreement informs associates of the potential threats imposed by the use of the Internet and communicates expectations of Internet use when representing OhioHealth. The requirements identified in this document ensure that the reliability and integrity of our business processes and information resources are maintained and ensure compliance with applicable rules and regulations.

Since the Internet is an open, unsecured network, systemintrusion and other exploitations are common. Each associate must be aware of the risks and take appropriate precautions to help protect corporate/patient Information assets. There is a risk that the privacy of information sent across the Internet, such as with electronic mail, could be violated. There is a risk that OhioHealth could be compromised by illegal access to systems or websites on the Internet. There is a risk that information sent globally across the Internet may misrepresent OhioHealth and/or be in non-conformance with legal requirements.

The requirements defined below have been established to protect the resources, data and network of OhioHealth from Internet threats and risks.

Acceptable Internet Use Requirements

Access authorization - Associate access to the Internet is authorized by OhioHealth. Access and use is limited to business purposes at OhioHealth. Personal use is minimized. Unauthorized access or attempts to use, alter, destroy, or damage data, programs, or equipment violates applicable law or hospital policy and could result in criminal prosecution and/or civil liability. For everyone's mutual protection, all system use, including electronic mail, may be monitored to protect against unauthorized use.

Business use - Internet access is provided as a tool for use in business operations. Inappropriate activity includes:

a. activities for personal use, profit, or hire;
b. activities that waste time or computing resources;
c. actions or activities undertaken on behalf of or activity as an agent for a non-OhioHealth related and unapproved organization, company, agency, or individual;
d. activities that are illegal under or intended to circumvent, federal, state, local or foreign laws;
e. unauthorized use of or reference to OhioHealth member companies' names or product information;
f. activities that could lead to accusations of unethical behavior;
g. activities thatcould damage OhioHealth's professional reputation.
h. activities that compromise privileged, confidential or proprietary information of OhioHealth and/or its patients.

Compromised Computers - Associates maintain an awareness of their computers and report to theInformation Security Director (by opening an Information Security Event Report on the intranet) any activity that is considered suspicious (e.g., unexplained appearances of new files or directories, corrupted files, access by unauthorized staff, access to inappropriate websites by staff) or any computers that are suspected of being compromised by malicious attack or by witting or unwitting dissemination of the access logons (e.g., passwords or PINS).

Suspicious Communications - Associates should log and report any suspicious communications to the Information Security Director (566-4800). Associates should never divulge information to unknown sources without proper identification, authorization, and confirmation of integrity. Upon management request, the Information Security Department has the authority to suspend or terminate computer access and/or communication activities determined to be suspicious. Any individuals involved in suspicious and/or unapproved activities and/or illegal actions will be directed to cease the activity. Any failure to comply with this agreement will be reported to the senior management of the area in violation and to the Information Security Director. Depending on the 11ature of the violation, Protective Services, the Privacy Officer and/or Human Resources may also be notified. Noncompliance may result in legal action and or associate disciplinary action, up to and including termination of employment.

I have read this Confidentiality Statement of Understanding and Internet User Agreement from OhioHealth and understand my responsibility to comply with the requirements. I acknowledge that if I fail to comply, I am subject to disciplinary action that could result in termination of employment or relationship with OhioHealth.

Name_____

Date_____ Signature _____

Acknowledgment

I certify that I have received, read and agree to abide by OhioHealth's Privacy Compliance: Training Basics.

Printed Name:

_____

Role while at OhioHealth:

_____

Date: _____

Signature:

_____

Name of OhioHealth Contact:

_____

Email Address of OhioHealth Contact:

_____

Patient Rights

Under the HIPAA Privacy Rule, patients have the right to:

- Copy and/or inspect much of the health information that OhioHealth retains on behalf of the patient.
- Request in writing that OhioHealth amend or correct health information contained in the patient's designate record set.
- Receive an accounting of certain disclosures of PHI that OhioHealth may have made about the patient.
- Request limits on how we use and disclose PHI for treatment, payment or health care operations
- Request to receive communications from OhioHealth by alternative means or at alternative locations.

Privacy Concerns

OhioHealth asks that if, during your experience, you become aware of any suspected compromise of the privacy, security, and/or confidentiality of PHI or have a privacy concern, you immediately (within 24 hours) report it to us.

Reports of privacy incidents may be made directly through any of the following means:

- Reporting to a supervisor or your OhioHealth designated point of contact;
- Calling the:
  - Ethics & Compliance Office at: (614) 544-4200; or
  - OhioHealth Ethics & Compliance Hotline at: (866) 411-6181
- Emailing the Privacy Compliance Team at: CompliancePrivacy@OhioHealth.com
- Submitting a report through OhioHealth's online reporting tool: www.mycompliancereport.com, using access code: OHH.

OhioHealth

OhioHealth's Privacy Compliance: Training Basics

At OhioHealth, we respect the privacy of our patients' information and we are committed to upholding the trust they place in us. We know that our associates; physicians on the Medical Staff(s); volunteers; observers, short-term visitors, students; non-associate professionals and consultants; independent contractors and their employees; as well as employees of contracted services are deeply committed to helping us uphold our patients' trust.

The purpose of this HIPAA Privacy Compliance Training for certain non-OhioHealth employed individuals is to explain the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Rule) in a way that will help you assist OhioHealth in safeguarding the privacy and security of our patients' protected health information (PHI) while enhancing your experience with us.

We ask that you please pay special attention to this training to ensure that the information about OhioHealth patients (that you may be made aware of during your time with us) is not inappropriately used and/or impermissibly disclosed.

OhioHealth is a health system that includes hospitals, clinics, community health centers, home health care and many other health care professionals. We work together to deliver quality care to our patients. Under the HIPAA Privacy Rule, OhioHealth is considered a covered entity, which includes health plans, health care clearinghouses, and many health care providers. In general, OhioHealth may share PHI as permitted by law to carry out treatment, payment and health care operations.

Protected Health Information (PHI)

PHI is a term used to describe personal medical information and includes any information, whether oral, written or recorded in electronic form, that is created or received by covered entities, and that identifies a person and relates to the past, present or future physical or mental health, or condition, treatment or payment for health care for such person.

Permitted or Required

A covered entity is permitted (but not necessarily required) to use and/or disclose PHI, without an individual's authorization, for the following purposes or situations: (1) To the Individual (unless required for access or accounting of disclosures, which OhioHealth is required to provide); (2) Treatment, Payment, and Health Care Operations; (3) Incident to an otherwise permitted use and/or disclosure; (4) Certain Public Interest and Benefit Activities; and (6) Limited Data Set for the purposes of research, public health or health care operations.

Minimum Necessary Standard

In general, the Minimum Necessary Standard requires covered entities to take reasonable steps to limit the use and/or disclosure of PHI to the minimum amount of information necessary to accomplish the intended purpose of the request for such information. It does not apply to uses or disclosure by a health care provider for treatment purposes. And it does not apply to:

- Disclosures made to the patient
- Uses or disclosures made pursuant to an individual's authorization.
- Uses or disclosures required for compliance with the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Rules.
- Disclosures to the Department of Health and Human Services when disclosure of information is required under the HIPAA Privacy Rule for enforcement purposes.
- Uses or disclosures that are required by other law, except as set out by such law.

Treatment, Payment and Health Care Operations

OhioHealth may disclose PHI for treatment activities of any health care provider; the payment activities for itself or for another covered entity; or the health care operations for itself, in general, or for another covered entity involving either quality or competency assurance activities or fraud and abuse detection and compliance activities, if both OhioHealth and the other covered entity have or had a relationship with the patient and the PHI pertains to such relationship.

"Treatment" generally means the provision, coordination or management of health care and related services among health care providers or by a health care provider with a third party; consultation between health care providers regarding a patient; or the referral of a patient from one health care provider to another.

"Payment" includes, among other things, activities of a health care provider to obtain payment or reimbursement for the provision of health care to a patient.

"Health Care Operations" are certain administrative, financial, legal and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment.

Test Your Privacy Knowledge

True or False:

1. As a Short-Term Visitor, Volunteer or Observer at OhioHealth, it is my responsibility to safeguard the privacy and security of patients' PHI.
2. OhioHealth is considered a covered entity under the HIPAA Privacy Rule.
3. PHI includes information that identifies a person and relates to the past, present, or future physical or mental health, or condition, treatment, or payment for health care for such person.
4. The HIPAA Privacy Rule does not apply to conversations.
5. If I do not use or disclose a patient's name it can't be a violation under the HIPAA Privacy Rule.
6. Patients do not have a right to receive a copy of their medical information.
7. The HIPAA Privacy Rule prevents OhioHealth from making reports to law enforcement.

Select one

8. The minimum necessary standard does not apply when PHI is being used or disclosed for which of the following purposes?
   A. Treatment B. Payment C. Operations

9. If, during your experience, you become aware of any suspected compromise of the privacy, security, and/or confidentiality of PHI or have a privacy concern, OhioHealth asks that:
   A. You immediately (within 24 hours) report it to us.
   B. Do not report it.
   C. Tell a friend or family member.

Fill in the Blank

10. The access code to make an online report through OhioHealth's online reporting tool: www.mycompliancereport.com is

    _____

OhioHealth

CLINICAL OBSERVER
CONSENT AND RELEASE

Observing clinical activities within OhioHealth hospitals is a special opportunity that is infrequently permitted. When observers are permitted it is essential that they understand the expectations placed upon them.

Providing quality health care services requires us to carefully credential every health care provider that performs hands-on patient care. The health care providers that come into contact with our patients are carefully selected and monitored. ***Under no circumstances may observers participate in any procedure they are observing.*** The observer's role is limited strictly to observing the clinical activities of the OhioHealth hospitals' personnel.

Observers will be provided with a brief orientation and will be expected to follow any instructions given by hospital personnel. Observers will also receive a brief orientation on hospital policy regarding confidentiality and exposure to blood borne pathogens. All patient information must remain confidential. Observers may not review patient charts nor may they share patient information with anyone outside of the hospital. Although it is unlikely, observers must be aware that they may risk exposure to infectious disease if they come into contact with blood or other body fluids. Observers will be expected to take precautions to prevent exposure such as wearing appropriate protective attire when instructed to do so.

Observers under the age of 18 must receive permission of their parent or guardian.

I, _____, have read the above and agree to comply with its requirements. I understand that as an observer I may not participate in clinical activities. As an observer I must be accompanied at all times by the hospital personnel I am observing. I agree to confidentially maintain any patient information that I may acquire as an observer. I further agree to follow any instructions given by hospital personnel while I am observing. I understand that I may be asked to leave a patient room or other area of the hospital at any time by the hospital personnel I am observing.

My participation as an observer is at my own risk. If I should become ill or be injured while observing or otherwise require medical attention, I will be attended to only as circumstances permit. I will be financially responsible for any medical treatment provided to me should I become ill or injured while observing. I agree to release OhioHealth hospitals from any and all responsibility or legal liability for any personal injuries or other claims that may arise from my participation as an observer.

_____

Name of program or school sponsoring observation activity (if applicable)

_____

Signature of Observer

Date:_____

_____

Signature of Parent or Guardian
if Observer is under 18