MEMORIAL HOSPITAL OF LARAMIE COUNTY
d/b/a CHEYENNE REGIONAL MEDICAL CENTER
CONFIDENTIALITY AGREEMENT

It is the responsibility of all Memorial Hospital of Laramie County d/b/a Cheyenne Regional Medical Center ("HOSPITAL") workforce members, as well as persons present at HOSPITAL for clinical experience purposes such as students, interns, faculty members and other persons participating in the training, to preserve and protect confidential patient, employee, and business information.

The federal Health Insurance Portability and Accountability Act ("HIPAA"), as well as State of Wyoming laws, govern the release of patients' individually identifiable health information by hospitals and other health care providers and specify that such information may not be disclosed except as authorized by federal and state law or the respective patient or individual pursuant to an authorization in compliance with such laws.

Confidential patient information includes: Any individually identifiable health information in possession or derived from a provider of health care regarding a patient's medical history, mental or physical condition or treatment, as well as the patient's and/or the patient's family members' records, test results, conversations, research records, and financial information. Examples of information that would be protected under HIPAA include, but are not limited to:

- Physical, medical, and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Patient insurance and billing records;
- Mainframe and department-based computerized patient data and alphanumeric radio pager messages;
- Visual observation of patients receiving medical care or accessing services;
- Verbal information provided by or about a patient; and
- Names, addresses, Social Security numbers, geographic information, birth dates, admission dates, discharge dates.

Confidential employee and business information includes, but is not limited to:

Employee home telephone number, address, electronic mail path;

- Spouse or other relative names;
- Social Security number or income tax withholding records;
- Information related to evaluation of performance;
- Other such information obtained from HOSPITAL records which, if disclosed, would constitute unwarranted invasion of privacy;
- Disclosure of confidential business information that would cause harm to HOSPITAL.

I understand and acknowledge that:

1. I agree to respect and maintain confidentiality of all discussion, deliberations, patient care records, and any other information generated in connection with individual patient care, risk management, and/or peer review activities.

2. It is my legal and ethical responsibility to protect, and I agree to protect, the privacy, confidentiality, and security of all medical records, proprietary information, and other confidential information related to HOSPITAL and its affiliates, including business, operational, employment, and medical information relating to HOSPITAL's patients, members, employees, and health care providers.
3. I agree to only access or disseminate patient care information in the performance of my assigned duties and where required by or permitted by law, and in a manner which is consistent with officially adopted policies of HOSPITAL or, where no officially adopted policy exists, only with the express approval of HOSPITAL's designated contact person or their designee. I agree to make no voluntary disclosure of any discussions, deliberations, patient care records or any other patient care, peer review, or risk management information, except to persons authorized by law to receive it in the conduct of HOSPITAL affairs.
4. HOSPITAL (administration, Privacy Officer, Security Officer, or Information Technology Department) may perform audits and reviews of patient records in order to identify inappropriate access.
5. My user identification (ID) is recorded when I access electronic records and I am the only one authorized to use my user ID. Use of my user ID is my responsibility whether used by me or anyone else. I will only access the minimum necessary information to satisfy my role or the need as requested by my Designated Faculty, HOSPITAL Contact Person, or their designee.
6. I agree to discuss confidential information only while at HOSPITAL and only as needed for cooperative education experience related purposes and to not discuss such information outside of HOSPITAL or within hearing distance of other people who do not have a need to know about the information.
7. That any and all references to HIV testing, such as any clinical test or laboratory test used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specifically protected under law and unauthorized release of confidential information may make me subject to legal and/or disciplinary action.
8. That the law protects psychiatric and drug abuse records, and that unauthorized release of such information may make me subject to legal and/or disciplinary action.
9. My obligation to safeguard patient confidentiality continues in perpetuity after completion of my cooperative education experience at HOSPITAL.

I hereby acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. In the event of a breach or threatened breach of this Confidentiality Agreement, I acknowledge and agree that HOSPITAL may, as applicable and as it deems appropriate, pursue disciplinary action, up to and including my exclusion from HOSPITAL and the termination of the cooperative education experience.

Signature: Date: ____

Print Name: ____

School/Program/Affiliation: ____

MEMORIAL HOSPITAL OF LARAMIE COUNTY
d/b/a CHEYENNE REGIONAL MEDICAL CENTER
CERTIFICATION STATEMENT

I certify that I am not now debarred, excluded, or otherwise ineligible for participation in any government health care program(s). I certify that I have not been convicted of a felony offense in the immediately preceding seven years. I certify that I am not now subject to or have reason to believe that I am subject to any specific investigations for violation of federal, state, or local criminal or civil law or regulation.

I agree to report in writing to Memorial Hospital of Laramie County d/b/a Cheyenne Regional Medical Center ("HOSPITAL") immediately if I become aware of such action, investigation, or effort to debar or exclude me from any government health care program. I understand that failure to disclose any relevant information regarding these matters is reason for immediate termination of my cooperative education experience at HOSPITAL.

Signature: Date: ____
Print Name: ____
School/Program/Affiliation: ______________________________________

If the foregoing person is under the age of eighteen (18), the person's parent or legal guardian, by his/her signature below, hereby agrees on the person's behalf to this Certification Statement.
Parent or Guardian:____
Signature Date : ____

MEMORIAL HOSPITAL OF LARAMIE COUNTY
d/b/a CHEYENNE REGIONAL MEDICAL CENTER
RELEASE AND CONSENT

I hereby release Memorial Hospital of Laramie County d/b/a Cheyenne Regional Medical Center ("HOSPITAL") for claims, expenses, damages, or liability for personal injury or damage to property, real or personal, that I may have or hereafter acquire, directly or indirectly, from the acts of HOSPITAL, its officers, boards, employees, faculty, students, interns, participants, medical staff, agents, and/or volunteers. I understand that my role at HOSPITAL will be to participate in the cooperative education program, which will include some patient treatment and care; provided, however my participation in any patient treatment and care will be subject to the agreement and consent of HOSPITAL, the patient and any applicable attending physician. Further, I understanding that I shall perform only those tasks delegated to me by HOSPITAL and/or the applicable attending physician. I further understand that I shall have no right of recourse, whether such right is one of due process or otherwise, against HOSPITAL in the event that HOSPITAL or my school terminate the Cooperative Education Agreement, which sets for the terms of my cooperative education experience at HOSPITAL, for whatever reason or in the event that HOSPITAL prohibits me from being present at HOSPITAL's facilities or from performing any services at HOSPTIAL. In addition, I acknowledge and agree that I am solely responsible for my own personal health insurance coverage throughout my cooperative education experience at HOSPITAL, and I acknowledge and agree that I am solely responsible for all medical expenses incurred during my cooperative education experience at HOSPITAL.

Signature: ____

Date: ____

Print Name: ____

School/Program/Affiliation: ____

If the foregoing person is under the age of eighteen (18), the person's parent or legal guardian, by his/her signature below, hereby agrees on the person's behalf to this Release and Consent.

Parent or Guardian: ____

Date: ____

Cheyenne Regional Medical Center – East and West

Address: 214 E 23rd Street
Phone: 634-2273 – General Hospital number

Contact Person: Karen Bowen RN
307-633-7364

Parking: **East Building:** Back of south building – lower lot. Do not park on street in front of houses
West Building: South end of Parking garage. Do not park on the first level or in any reserved spots. Please do not park on the street.

Entrance to facility Front door

Coat and Personal Belongings: In room on assigned floor

Report: Report to nurses' station of assigned unit

Food Service: **Cafeteria located in West Building**
No food option at East Building please bring your own

Emergency Codes: Dial 2211 and tell operator what the emergency is.

Other: CRMC is 100% non-smoking facility. This includes the grounds area in front of the build