INTERNSHIP HIPAA CONFIDENTIALITY AND NONDISCLOSURE STATEMENT

I, _____, who will be participating as an unpaid intern at

_____ (*therapy practice*), am aware of the Practice's regulations and policies issued under the Health Insurance Portability and Accountability Act of 1996 (*also known as the HIPAA Privacy Rule*).

I understand that all client information, including clinical and medical records, billing and financial data, and other personal information, is confidential.

I agree to keep all client information confidential. I agree to comply with all Practice Privacy Policies and Procedures, including those implementing the HIPAA Privacy Rule.

I understand that if I violate client confidentiality by using or disclosing client information improperly, I may be subject to disciplinary action, including having my Internship immediately terminated.

I understand that no information about any clients I may observe or hear discussed while on the Internship or at any time thereafter may be transmitted to any third party or person (except other members of the clinical team caring for the client) via text message, posting on any social network or another online site, or via any other written or verbal communication.

I understand that if I have any questions or concerns about the Privacy Rule and/or the proper use or disclosure of client information, I shall ask my supervisor, _____ (*name of supervisor*).

I understand and agree these Privacy Policies and Procedures will apply to all client information, even after my Internship has been completed.

I certify that I have read _____ (*therapy practice*)'s HIPAA Policy regarding confidentiality of Protected Health Information.

_____

Signature

_____

Typed or Printed Name

_____

Date