



# Statement of Comprehension Non-employee

## Cullman Regional Medical Center (CRMC) Confidentiality Statement

**Confidentiality is a basic element of the operation of Cullman Regional Medical Center. Release or use of any employee, patient/customer/resident, or other company information is a violation of this policy including release or use for personal benefit.**

The care and treatment of customers/patients are highly personal in nature. Therefore, all information concerning patients' medical or personal matters will be kept strictly confidential. This information will be discussed only with the patients attending physicians and the authorized personnel directly responsible for the patient's care and treatment. Care will be exercised to be certain that authorized individuals do not overhear any discussion of confidential information. All individuals allowed in the patient care areas have a legal obligation to ensure that patient's medical information is held in strict confidence and only discussed with those persons involved with the care of that patient.

I understand that I am responsible for strict compliance with all privacy and confidentiality requirements, policies and procedures, including the privacy and security of confidential information obtained during my visit at CRMC at all times, whether I am off-campus or within CRMC facilities. Confidential information includes any medical information relating to patient care - including, but not limited to, Protected Health Information - privacy information - including, but not limited to dates of birth and social security numbers for patients - and CRMC's confidential business information - including, but not limited to billing practices, accounting information, human resources information or information from other administrative areas.

I understand that I am legally bound to comply with restrictions on sharing Personal Health Information obtained while at CRMC

**I acknowledge Cullman Regional Medical Center's Confidentiality statement** and that it is my responsibility to become familiar with the information regarding Confidentiality/HIPAA. I also understand that it is my responsibility to consult my instructor, the department director (or designee) if I have any questions regarding policies and/or procedures during my visit at CRMC.

**I verify that I have read and understand the information presented in CRMC Hospital Orientation Packet.** I have been given the opportunity to clarify any part of the information I may have questions/concerns about. I understand the expectations of Cullman Regional Medical Center and agree to abide by its policies, procedures, requirements, and practices during my assignment here.

### MEDICAL INFORMATION

Please answer the following questions and check the appropriate column to indicate that you have not had any of these symptoms in the last 12 months.

These symptoms sometimes mean TB and should be evaluated by a physician. If any of these symptoms develop at any time please contact your physician for evaluation.

SYMPTOM	YES	NO
<i>Chronic Cough</i>		
<i>Feeling Tired All the Time</i>		
<i>Weakness</i>		
<i>Unexplained Weight Loss</i>		
<i>Loss of Appetite</i>		
<i>Spitting up Blood</i>		

**I understand that I will be observing only and will have no physical contact with a patient. I have answered the Medical History questions correctly and understand the importance of the symptoms listed above.**

Print Name: \_\_\_\_\_ Contact Numbers: \_\_\_\_\_<sup>2<sup>nd</sup></sup> \_\_\_\_\_

Please list any relatives you have working at CRMC: 1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

*Schedule observation time on a different date/time relatives are working.*

Affiliation (High School, College, Company, Vendor, etc.): \_\_\_\_\_

Observation area you are requesting to shadow in: \_\_\_\_\_

Sign Name: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_