USF HEALTH
Security and Confidentiality Agreement
For Volunteer in Patient Care or Clinical Research Area(s)

As a Volunteer, and as a condition of my participation, I recognize that I may have access to certain information that is confidential and constitutes valuable, special and unique property of the University of South Florida (USF). I agree to the following:

1. I understand that I am responsible for complying with the HIPAA regulations, state law, USF policies and USF Health Standard Practices and Procedures, and that I must protect patient privacy and confidential information.
2. I will treat all information received which relates to the patients of USF Health and its affiliated hospitals, as confidential and privileged information, keeping confidential information in an area not visible to unauthorized parties. Paper records containing confidential information that are to be discarded are to be shredded or placed in locked shredding bins until destroyed. Conversations involving confidential information should be protected by moving to an enclosed office or other private area and conducted in a low tone of voice.
3. I will not access patient information unless I have a need to know this information as part of my assigned observation activities.
4. I will not disclose information regarding USF/USF Health patients to any person or entity, other than as necessary and as permitted in accordance with instructions by my Sponsoring Faculty Member.
5. I will not take patient information from the premises of USF/USF Health in paper or electronic form.
6. During or subsequent to my time at the University, I agree that I will not disclose to others, use, copy or permit to be copied, without the University's express prior written consent, any confidential or proprietary information which concerns the University or its patients, including but not limited to costs, prices and treatment methods at any time used, developed or made by the University and which is not otherwise available to the public.
7. Upon leaving, I agree to continue to maintain the confidentiality of any information I learned while at the USF/USFHealth and agree to turn over any keys, access cards, or any other device that would provide access to the USF/USFHealth or its information.

I understand that violation of this agreement could result in suspension or termination of the approved volunteer activity. I also understand that USF does not provide me with health insurance.

_____
Volunteer Name (print)

_____ _____/_____/_____
Volunteer Signature (if under 18 parent/guardian) Date

_____
Witness Name (print)

_____ _____/_____/_____
Witness Signature Date