



## **HIPAA Understanding Form**

### **Student's Understanding of Patient Record Information Office of the Registrar**

Student ID #: \_\_\_\_\_

The Department of Health and Human Services Oversees the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Act requires health care providers, to include mental health services, to secure and protect patient information. WJC provides a variety of clinical, psychoeducational, and other services to persons through the Brenner Center, Freedman Center, the PATHWAYS program, and other affiliated programs. WJC students at field placement sites for practicum and internship training should always be trained by the sites their specific HIPAA policies.

HIPAA protects patient medical/clinical records, viewing and other access to these records, storage of records, and communication by any electronic means (e.g., computers, fax, web). WJC students through field placements and some academic coursework deal with client/patient information and so WJC informs students that HIPAA regulations require protection of the privacy of any individually identifying patient/client information, and accessing and storing of records containing patient/client information.

- By checking this box I affirm that I understand that I have the responsibility to safeguard Protected Health Information (PHI) as directed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and to seek supervision if I have any questions about my obligations to protect patient/client privacy.
- By checking this box I affirm that I understand that my personal electronic devices may not be used to store, maintain, or communicate any Protected Health Information (PHI) of a patient/client.
- By checking this box I affirm that I understand that I will never have conversation, discussion, or develop written or electronic materials that improperly discloses PHI, and shall develop my own system(s) for coding or otherwise protecting the privacy of patients/clients (PHI) when utilizing training experiences with patients/clients to complete WJC graduate training.

Print your Name: \_\_\_\_\_

I have read and understand that my WJC coursework and field site training involves working with patients through provision of intake, assessment, clinical intervention, counseling, psychoeducational, or other professional psychological services. I understand that I cannot disclose (including in WJC courses) any patient names or other protected health information (PHI) which might result in the identification of individual patients/clients unless there is a HIPAA provision authorizing the disclosure. I further understand that I shall never store PHI on any personal electronic device. And that if I need notes or information for courses these needed to be coded or otherwise de-identified to protect the PHI of patients/clients.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*