CONFIDENTIALITY AGREEMENT

Patient and Family Advisory Committee (PFAC)

The Health Insurance Portability and Accountability Act or "HIPAA" is a federal law that sets standards for protecting the use and disclosure of patients' personal health information. This information is referred to as "protected health information" (PHI) and includes any information that may identify the patient and/or reference any visit to The University of Kansas Health System. Information, may include but is not limited to, name, address, phone number, date of birth, email address, financial information, and treatment information.

In my role as a member of the Patient and Family Advisory Committee (PFAC) for The University of Kansas Health System (including but not limited to Primary Care, Internal Medicine, Family Medicine, Pediatrics and Community Departments), I may have exposure to sensitive and confidential information. Discussion of confidential information may be required to improve the performance and care The University of Kansas Health System and Physicians provide to patients. As a non-employed member of the PFAC, I will be required to follow all State and Federal laws pertaining to confidentiality and privacy of patients. As The University of Kansas Health System and its Physicians are committed to providing the best care for patients, it is equally important to protect the privacy of patients. I understand that discussion of protected health information and sensitive information is confidential and I will not discuss it outside of this committee with friends, family, or acquaintances.

I understand that the information I access through PFAC meetings is privileged, and/or confidential, and is to be used only in my performance as a committee member. I agree that I will not divulge confidential information outside the scope of the committee. If I have any concerns about the information received during my participation in this committee, I will notify the Patient and Family Advisory Committee staff. By signing below, I have read the agreement and agree to comply with the policy as stated. I am aware that this agreement remains in place after my committee term concludes. I further understand that any breach of this policy will result in termination of my role on the Patient and Family Advisory Committee.

Member's Name (please print): ____

Member's Signature: ____ **Date:** ________________

PFAC Committee (or Designee) Signature: _____________________________________ **Date:** ___________