

**Patient Rights and Confidentiality Information Agreement
University of Tennessee Health Science Center, College of Dentistry
Office of Clinical Affairs Form**

“Patient Rights”

Registered patients of the College of Dentistry have the right to: (1) Considerate, respectful, confidential treatment; (2) Continuity and completion of treatment; (3) Access to complete and current information about their condition; (4) Knowledge of each treatment procedure and the cost of that procedure before it is begun; (5) Information about the type of treatment recommended, the benefits of that treatment, and the risks involved with the treatment. If alternate methods of treatment are available, information of those alternative treatment methods and their associated benefits and risks; (6) Refuse treatment and an explanation of the risk involved if the treatment is not done; (7) Access to care for emergency situations, (8) Treatment that meets the standard of care in the profession; and (9) Access to a patient representative.

I will extend to patients the above listed rights.

“Security and Confidentiality of Information”

Each faculty member, student, staff, and other employee of the University of Tennessee Health Science Center College of Dentistry who is afforded access to confidential and/or protected health information agrees to abide by the following terms:

A. Patient care information, whether written, unwritten, or in electronic (computer) form, may be accessed only by students, employees, or authorized contracted personnel who need that information to perform their job or contractual responsibilities. **Patient records, any of its parts or contents, or any copies of such, may not be taken outside of the Dunn Building without the written permission of authorized personnel of the Office of Clinical Affairs.**

B. I understand that protected health information belongs to the patient and that I am only the caretaker and must guard the information appropriately. This includes, but is not limited to: 1) keeping patient information secure, private, and out of public view; 2) protecting computerized data by logging off when leaving a work station; 3) not discussing patient specific issues where the conversation may be overheard, such as elevators and hallways; 4) not discussing patient specifics at home or at social events; 5) not speaking in a manner where the conversation may be inappropriately overheard, such as speaking loudly at your desk or work station.

C. I understand that patient information is not the only confidential information within the University environment. Other confidential information includes, but is not limited to, student, employee, financial, or research information, computer passwords, telephone access codes, etc.

D. I understand and agree that I may only access information necessary to perform my job responsibilities. I agree not to disclose, communicate, or use any confidential patient, student, employee, financial, or research information, however discovered or obtained, in any manner whatsoever other than within the course of my job responsibilities. Further, I agree to limit the dissemination of information only to those persons who have a need to know. I agree that my personal access codes (computer passwords, telephone access codes, etc.) are not to be shared with anyone.

E. I agree that upon completion of job tasks or activities any copies or downloaded and printed confidential information will be disposed of by shredding.

F. I understand that the confidentiality of information survives the termination of my relationship with The University of Tennessee.

G. I understand that if I do not keep this information confidential, or if I allow or participate in the inappropriate dissemination of (or access to) confidential information, that my actions will result in disciplinary action, as per the applicable University Code of Conduct, Faculty Handbook, Student Handbook, state and/or federal laws, which may include termination, monetary sanctions, civil and/or criminal liability.

I have read, understand, and agree to abide by the terms of this Agreement on Patient Rights and on security, protection and disclosure of confidential information.

(Print Name)

(Department)

(Signature)

(Date)