Endocrine & Diabetes Plus Clinic of Houston

832-968-7003
admin@diabetesplusclinic.com
endocrine.plus/training

Student & Observer HIPAA Confidentiality Agreement

Required before your first day in clinic · Retained in the clinic's training file

SECTION 1 — LEARNER INFORMATION

Full legal name _____ **Date of birth** _____

School, program or institution _____ **Training level (observer, MS, NP/PA, resident, etc.)** _____

Rotation start date _____ **Rotation end date** _____ **Supervising physician** _____

Email address _____ **Mobile telephone** _____

SECTION 2 — WHAT I AM AGREEING TO

I am being given access to a clinical environment in which I will see, hear and otherwise encounter **Protected Health Information (PHI)** — any information that identifies a patient or could reasonably be used to identify them, in any form: spoken, written, printed, photographic or electronic. This includes names, dates, addresses, telephone numbers, insurance and account details, photographs, medical record numbers, diagnoses, laboratory results, medications and images.

I understand that the Health Insurance Portability and Accountability Act (HIPAA) and its Privacy and Security Rules apply to me for the entire time I am present in the clinic, that my access is granted solely for educational purposes, and that this access is a privilege which may be withdrawn at any time.

SECTION 3 — MY OBLIGATIONS

I agree that I will:

- Keep confidential all PHI I encounter, and access or view only the information necessary for my learning, with permission.
- Discuss patients only with clinic staff directly involved in that patient's care, and only within the clinic, never in public areas, corridors, lifts, waiting rooms or parking areas.
- Log out of, lock or close any workstation, device or record before leaving it, and never use another person's login credentials or allow anyone to use mine.
- Immediately report to my supervising physician or the clinic manager any actual, suspected or accidental disclosure of PHI, including my own errors.
- Return or securely destroy any clinic material in my possession at the end of my rotation, and remove any clinic-related information from my personal devices.
- Follow all additional privacy, security and conduct policies of the clinic, including those set out in the Rotation Handbook at endocrine.plus/learner-goals-expectations.html.

I agree that I will **not**:

- Take, store or transmit any photograph, screenshot, video or audio recording of a patient, a record, a screen or any part of the clinical area.
- Post, describe or allude to any patient, case, encounter or clinic event on social media or any messaging platform, even if I believe the details are de-identified.
- Remove any record, document, printout, specimen label or copy containing PHI from the clinic premises.
- Copy PHI onto a personal device, drive, cloud account, notebook or e-mail account, or use PHI in a case log, assignment, presentation or portfolio without written clinic approval and full de-identification.
- Access the record of any person — including myself, a family member, a friend, a colleague or a public figure — whom I am not directly assisting in a supervised educational capacity.
- Enter, sign or release any order, prescription or result, or give medical opinion or advice to a patient.

- Use artificial intelligence tools, translation services, note-taking apps or any external service that would transmit PHI outside the clinic's approved systems.

SECTION 4 — DURATION AND CONSEQUENCES

My duty of confidentiality is **permanent**. It continues without limit of time after my rotation ends, after I leave the clinic, and after I complete my training program.

I understand that any breach may result in immediate removal from the clinic, notification to my school or training program, and referral to the appropriate licensing or credentialing body. I further understand that HIPAA violations carry civil and criminal penalties imposed by federal and state authorities directly upon the individual responsible, and that these penalties apply to students and observers.

SECTION 5 — ACKNOWLEDGEMENT AND SIGNATURE

I have read this agreement in full. I have had the opportunity to ask questions and any questions I asked have been answered. I understand my obligations and I agree to be bound by them.

Signature of learner	Printed name	Date

If the learner is under 18 years of age, a parent or legal guardian must also sign.

Signature of parent / legal guardian	Printed name	Date

FOR CLINIC USE ONLY

Received by (print & sign)	Role	Date received

Photo ID verified (initials)	Immunization records on file (initials)	Filed in training record (initials)

Retain this signed agreement in the clinic's training file. Form reference: EDPC-TRN-HIPAA · Version 1.0 · August 2026