INTERN/VOLUNTEER INFORMATION SHEET

Please print name as it appears on your Social Security Card:

NAME: _____ _____ _____
Last Name First Name Middle Initial

STREET ADDRESS _____

CITY _____ COUNTY _____ STATE _____ ZIP _____

MAILING ADDRESS _____ SAME? YES ☐ NO ☐

CITY _____ COUNTY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

PRIMARY EMERGENCY CONTACT _____ (Name); RELATIONSHIP TO YOU _____

PRIMARY ADDRESS _____ SAME? YES ☐ NO ☐

CITY _____ COUNTY _____ STATE _____ ZIP _____

PHONE _____; TYPE PHONE (i.e., cell, work) _____

ALTERNATE PHONES _____; TYPE PHONE (i.e., cell, work) _____

2nd EMERGENCY CONTACT _____ (Name); RELATIONSHIP TO YOU _____

ADDRESS _____

CITY _____ COUNTY _____ STATE _____ ZIP _____

2nd PHONE NUMBERS _____; TYPE PHONE (i.e., cell, work) _____

ALTERNATE PHONES _____; TYPE PHONE (i.e., cell, work) _____

GENDER (check one) ☐ MALE ☐ FEMALE

Please check one in each group:

Ethnic Group
- ☐ American Indian
- ☐ Asian
- ☐ African-American
- ☐ Hispanic
- ☐ Multiracial
- ☐ White

Marital Status
- ☐ Divorced
- ☐ Married
- ☐ Separated
- ☐ Single
- ☐ Widowed

Are you related to any employee in the Cherokee, Fannin, Gilmer, Murray, Pickens, Whitfield County Health Depts, Clinic Sites, District Office or Programs within the North GA Health District? If so, please write their name and the relationship below. ☐ Yes ☐ No

Name: _____; Relationship: _____

11/2016

Important Information on CBOH HIPAA Privacy Policies and Procedures

"HIPAA" is the short name for the Health Insurance Portability and Accountability Act of 1996. Part of that Act provides for the safeguarding of each individual's personal health information or "PHI." The federal Department of Health and Human Services ("HHS") has issued a "Privacy Rule," effective April 14, 2003. The Privacy Rule details when and how the privacy safeguards apply, and the administrative requirements "covered entities" such as CBOH must follow. CBOH has adopted privacy policies and procedures in order to comply with the Privacy Rule. All members of CBOH's workforce will be trained on those CBOH policies and procedures. Training will be done in a manner suitable to the employee's role within the agency and the extent of the employee's involvement with PHI. Every member of the workforce, including volunteers and trainees, should keep in mind the following key points from CBOH policies and procedures:

- CBOH has issued a "notice of privacy practices" stating how it will use and disclose an individual's PHI. The notice will be available in paper and electronic formats.
- CBOH must obtain written agreements from its contractors or "business associates" reasonably assuring that their activities will meet HIPAA privacy requirements.
- Normally, an individual's written authorization should be obtained before PHI may be used by CBOH or disclosed to others.
- When PHI is used or disclosed without a written authorization, the use or disclosure should only be of the minimum PHI necessary to accomplish the purpose for which the use or disclosure is being made.
- An individual has the right to access the individual's own PHI; to request limitations on its use and disclosure, including restricting the persons to whom disclosure may be made; to request amendment of the individual's PHI; and, to request an accounting of disclosures made without written authorization or other legal authority. CBOH must maintain records of those disclosures and keep the records for six years.
- An individual who believes his or her rights under the Privacy Rule have been violated has a right to make a complaint to the agency management staff or to the Secretary of HHS.
- CBOH has designated a Privacy Officer responsible for developing and implementing privacy policies and procedures, which provide for agency Coordinators responsible for providing information, receiving complaints and responding to inquiries.
- Both civil and criminal penalties may apply if privacy violations occur.

The complete text of CBOH's policies and procedures is available to all North Georgia Health District employees on the Agency's website: www.nghd.org under "About US" tab.

Please keep a copy of this document for ready reference, sign and date below and return it to the Personnel Office. Thank you for helping CBOH achieve HIPAA compliance.

_____	_____
Signature	Date
_____	_____
Please print Name clearly	Division / Unit

Confidentiality Agreement

I understand that the County Boards of Health within the North Georgia Health District (NGHD) has a legal and ethical responsibility to maintain patient privacy, including obligations to protect the confidentiality of patient information. I understand that during the course of my assignment as a volunteer/intern with NGHD, I may see or hear other confidential information, such as financial data and/or operational information pertaining to NGHD agency business. It should also be maintained as confidential and privileged.

As a condition of my volunteer/intern assignment with NGHD, I understand that I must sign and comply with this agreement. By signing this document, I understand and agree that: I will disclose patient information and/or confidential/privileged information only if such disclosure complies with NGHD policies, and is required for the performance of my assignment. My personal access code(s), user ID(s), access key(s) and password(s) used to access computer systems or other equipment are to be kept confidential at all times. I will not access or view any information other than what is required to do my assignment. If I have any questions, I will immediately ask my preceptor for clarification.

I will not discuss any information pertaining to a patient in an area where unauthorized individuals may hear such information (ex. hallways, elevators, break areas, public transportation, restaurants, home, social events). I understand that it is not acceptable to discuss any NGHD patient related information in public areas, even if the patient name is not used. I will not make inquiries about any NGHD information for any individual or party who does not have proper authorization to access such information. I will not make any unauthorized transmissions, copies, disclosures, inquiries, modifications or purging of patient information or confidential information. Such unauthorized transmissions include, but are not limited to; removing and/or transferring patient information or confidential/privileged information from the NGHD computer system to unauthorized locations (ex. removable drives, personal email, home).

Upon termination of my volunteer/intern assignment with NGHD, I will immediately return all property (e.g., keys, documents, ID badges, etc.) to my supervisor. I agree that my obligations under this agreement regarding patient information will continue after the termination of my volunteer/intern assignment with NGHD. I understand that a violation of the agreement may result in termination of my volunteer/intern assignment with NGHD and/or civil and criminal legal penalties.

I understand that any confidential/privileged information or patient information that I access or view at NGHD does not belong to me. I have read the above agreement and agree to comply with all its terms as a condition of continuing a volunteer/intern assignment.

Signature: _____ DATE: _____

Name (Please Print) _____