Observation Form for Visitors

The University of Maryland School of Dentistry (UMSOD) must abide by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This act sets standards for national electronic health data systems, simplifies submission of electronic insurance claims. In addition, it contains comprehensive regulations safeguarding the privacy of patients.

Before you will be allowed to observe the treatment of patients in the UMSOD, you will need to sign a Confidentiality Agreement. By signing this agreement, you agree to abide by the privacy regulations of HIPAA. Briefly, you cannot disclose any of the following patient information:

- Name
- Address
- Birth date or age
- Telephone & FAX number
- Email address
- Social Security number
- Medical record number
- Health plan beneficiary
- Number
- Account number
- Certificate/ license number
- Vehicle ID and serial numbers
- Device ID and serial numbers
- Web addresses
- Internet Protocol address numbers
- Biometric Ids
- Or take full face photographs of patients

Examples of violations

- Telling a friend that someone is a patient at the UMSOD.
- Talking about the patient in an identifiable manner in the hallway or elevator.
- Disclosing that someone is a patient in a situation that is not related to the patient's treatment (i.e., telling others about famous people you saw treated at the UMSOD).

There are stiff fines for the violation of these regulations,
$50,000 fine + one year in prison for improper disclosure of health information.
$100,000 fine + five years in prison for obtaining health information under false pretenses.
$250,000 fine + ten years in prison for using health information for personal gain.

CONFIDENTIALITY AGREEMENT
University of Maryland School of Dentistry
650 West Baltimore Street, Baltimore, Maryland 21201

In consideration for being given access to the University of Maryland School of Dentistry ("School of Dentistry") Clinic for purposes of observing treatment being delivered in a clinical area, I agree to abide by all federal and State law pertaining to privacy of medical information, all School of Dentistry policies on privacy and the terms of this Confidentiality Agreement. I understand I will not be permitted to enter the School of Dentistry Clinic unless (1) I sign this agreement and (2) any patient whose treatment I am to observe first consents to my presence.

A. I agree that all personal information I see, hear or otherwise obtain during my visit to the School of Dentistry Clinic is strictly confidential.

B. I have been advised of the importance of complying with all relevant state and federal confidentiality laws including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

C. I agree to keep confidential all patient information, including but not limited to, information (1) provided orally, (2) contained in patient records, (3) obtained incidentally, and (4) maintained in the School of Dentistry's electronic information systems.

D. I may not use personal information or protected health information I acquire at the School of Dentistry Clinic for any purpose.

E. I may only disclose personal or health information I acquire at the School of Dentistry if mandated by a law, regulation or government order, and provided such disclosure does not violate School of Dentistry policy, HIPAA or applicable state law. Further, I must first give the School of Dentistry written notice and an opportunity to object, before I comply with any such mandated disclosure.

F. I understand that my failure to comply with the provisions of this agreement may subject me to disciplinary action by the University of Maryland Baltimore and the School of Dentistry, as well as legal action, including, but not limited to, civil or criminal prosecution.

G. Should I violate this Confidentiality Agreement, I consent to permit the School of Dentistry to release information about my violation to persons, institutions, regulatory authorities and others having a legitimate interest in my violation as it pertains to my fitness as a health professions student and as a licensed health care professional.

READ CONFIDENTIALITY AND OBSERVATION FORM AND AGREED:

Signature_____ Date: _____

Print Name_____

Address: _____, Country: _____

Approval Signatures:

Sponsor/Originator: _____ Date: _____

Department Chairman: _____ Date: _____

Approval Dr. DePaola: _____ Date: _____