BENTON COUNTY FIRE PROTECTION DISTRICT #2
P.O. Box 719. Benton City, WA. 99320
Station 210: 1304 Dale, Station 220: 49504 N. Whitmore P.R N.W
Phone: 509-588-3212 Fax: 509-588-4343

HIPAA PRIVACY RULE
CONFIDENTIALITY AGREEMENT

As a participant in the city of BCFPD 2 Ride-Along Program, you may become aware of protected health information (PHI) that is confidential in nature. Disclosure of PHI is protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please indicate your understanding of the following HIPAA information with your initials.

_____ PHI is any "individually identifiable health information," which includes information about an individual's past, present or future physical or mental health or condition; the provision of health care to the individual; or the past, present or future payment for the provision of health care to the individual.

_____ PHI includes information that identifies the individual or which can reasonable be used to identify the individual. Individually identifiable information includes many common identifiers such as name, address, birth date, and Social Security number.

_____ HIPAA prohibits the unauthorized disclosure of PHI to anyone outside the organization, whether oral, written, photographic, video or electronic.

_____ I agree that I am required as a ride-along participant with BCFPD 2 to comply with all confidentiality policies during my entire experience with the organization.

_____ I understand that potential civil penalties for unauthorized disclosure of PHI are $100 for each violation, up to a maximum of $25,000 per year for all violations. Criminal penalties can include one to 10 years of prison with financial penalties ranging from $50,000 to $250,000 for violations knowingly committed under false pretenses or with the intent to use PHI for malicious harm, personal gain or commercial advantage.

_____ If I, at any time, knowingly or inadvertently breach these patient confidentiality policies, I agree to notify the Training Chief of BCFPD 2 immediately. In addition, I understand that a breach of patient confidentiality may result in the termination of my privileges to ride with BCFPD 2. It may also include the recommendation by this department for disciplinary action by my sponsoring agency, if applicable.

I have read and fully understand the HIPAA confidentiality agreement and agree to all conditions set forth as a condition of my ride-along.

APPLICANT:

_____

Name (printed) *Signature* *Date*

Copy of ID is REQUIRED