# Washington County Emergency Medical Services

*"SERVING WASHINGTON COUNTY SINCE 1979"*

## Non-Student / Non Employee Third Party Rider
## Acknowledgement of Patient Confidentiality

I, _____(Participants Name) understand that all information I obtain about any and all patients at Washington County EMS is confidential as it pertains to the patients Personal Health information (PHI). PHI includes, but is not limited to, the patients age, name, address, phone numbers, medical record numbers, health plan beneficiary numbers, license plate numbers, vehicle serial or identification numbers, URL's, IP address fingerprints, voice prints and full face photographs. Any information that can reasonably point to the identity of a patient is confidential and cannot be release without prior written authorization from:

Washington County EMS
Amy Klussmann, Compliance Captain
1875 HWY 290 West
Brenham, Texas 77833
Phone: 979/277-6267
Fax: 979/277-6270

As a participant, I understand that I will have access to the above identifiers and that I will not include any of these identifiers and that I will not include any of those identifiers in my paperwork or notes. I also understand that I am not permitted to discuss with anyone outside of the original crew providing patient care. Be advised, any information which could reasonably identify the patient will be as allowable by requirement of the law. Anytime this type of disclosure is made, the provider must inform the patient the type of disclosure made and for what reason this was done. The exception to this would be child abuse.

If an illegal disclosure of information is made, either accidentally or maliciously, it is the responsibility of the participant to inform the Compliance Captain immediately. If such a disclosure is made, the participant will be removed from the third rider program. The participant will also no longer have the ability to be a third rider with Washington County EMS in the future. The participant will also be subject to both Civil and Criminal penalties for disclosure of PHI under the Health Insurance Portability and Accountability Act of 1996.

By signing the form, I acknowledge that I have read and understand the information contained in this document. I also understand that I have had an opportunity to ask questions about information that I do not understand.

_____
Participants Printed Name:

_____
Witness Printed Name:

_____

_____

_____
Participants Full Address:

_____
Witness Full Address:

_____
Date:

_____
Date: