Privacy Form for digital sherpa™ Workshop Volunteers

As a digital sherpa™ volunteer, I agree to comply with all policies and procedures of the Patient Empowerment Network that relate to my volunteer services. I further agree to comply with laws and regulations relating to confidentiality of medical records and protected health information ("PHI"), including the Health Insurance Portability and Accountability Act ("HIPAA").

I understand that, as part of the digital sherpa™ workshop experience, I may be given access to PHI or other confidential patient information at the patient's discretion. I agree not to share or disclose such information, or any other private or sensitive information, with anyone outside the digital sherpa™ program or workshop experience. I will further make sure to limit my access only to information relating to matters where patients request help or assistance, and as otherwise required under HIPAA.

I have read and agree with the requirements above, and I understand that I may be dismissed from my volunteer duties if any of these requirements are violated.

Signature: ______________________________________ Date: ______________________

Printed Name: ____