CONFIDENTIALITY STATEMENT

I understand that in the performance of my ombudsman duties, I may have access to confidential resident information. No disclosures shall be made outside of the program without a court order or without the consent of any named resident or complainant unless the disclosure is made without the identity of any of these individuals being disclosed.

I will, to the best of my ability, take all necessary precautions to maintain the confidentiality of all resident and complainant information. This includes obtaining authorization for the release of health information as required by federal and state law. This also includes proper storage, retention, and disposal of health information that identifies the individual or can be used to identify the individual.

Furthermore, I understand that unredacted surveys provided by the Office of Health Care Quality (OHCQ) may not be shared with anyone other than an ombudsman representative. All unredacted surveys that I request from OHCQ will be requested using my work email and will not be attached or sent to a non-secure email account or a non-work account. If I print an unredacted survey, it will be kept in a locked drawer when not in use. If I save an unredacted survey electronically, it will be saved in a drive, file, or password protected email account that is only accessible by ombudsmen.

I understand that failing to adhere to this confidentiality agreement may result in: (1) the revocation of my ombudsman certification, (2) termination of my position, and (3) possible criminal and civil penalties.

Printed Name ____ Date _____________

Signature ____ Date _____________

Witness ____ Date _____________