

**STUDENT/FACULTY CERTIFICATION ATTACHMENT
to EXHIBIT A
of the PROGRAM AGREEMENT
between
Children's Hospital and Health System, Inc. and**

**the Board of Regents for the University of Wisconsin System on behalf of the
University of Wisconsin-Milwaukee**

The undersigned agrees that any information or knowledge acquired or received by me during the course of my experience at CHHS, including but not limited to patient/client data and patient/client care information, CHHS's business affairs, methods of operation, and computer processing systems ("Confidential Information") is confidential. I agree to maintain the confidentiality of and not to disclose or use Confidential Information during and after my experience at CHHS ends, without CHHS's prior written consent.

I understand that information contained in medical or electronic records is the property of Children's Hospital and Health System, Inc. and that patients/clients have the right to expect that records will be managed confidentially. I agree to follow all CHHS policies and procedures regarding patient/client privacy and I understand that any violation of those policies could result in immediate dismissal from the CHHS assignment, as well as federal, civil and/or criminal penalties. I further agree as follows:

1. I am responsible for protecting the confidentiality of patient/client information disclosed to me.
2. I will only access patient/client information that is necessary for my assignment and I will not disclose information to other students or faculty or to employees of Children's Hospital and Health System unless they need it to do their job.
3. I will refer all request for copies of medical records to the Medical Records Department.
4. I will not discuss patient/client information in public places (for example, elevators or the cafeteria).
5. I will not disclose patient/client information outside CHHS.
6. I will review CHHS privacy policies and consider how they impact my assignment. If I have questions or concerns about patient privacy, I will contact the CHHS Privacy Officer at (414) 266-2215.

Accepted and agreed to:

By: YOUR SIGNATURE

Student/Faculty
PRINT YOUR NAME

Print Full Name

Date: TODAY'S DATE
