



central illinois  
**NEUROSCIENCE**  
**FOUNDATION**

**2017 HIPAA COMPLIANCE FORM**  
**Neuroscience Case Review Conference Faculty, Participants & Attendees**

By signing this form, you agree to maintain the confidentiality of patient information including the nature of the illness, financial background, family life, or other matters of a personal nature that may be discussed during the course of this conference in compliance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA). Under no circumstances should this information be discussed unless it is required directly for the treatment or care of the patient. Violation of this agreement may result in civil and/or criminal liability under Federal and State laws.

- I agree that I will maintain the confidentiality of all information discussed regarding patients and staff.
- I agree not to discuss in any manner, with any unauthorized person, information that would lead to identification of individuals described, presented or involved in the care and management of patient's presented at case conference.
- I agree to respect the privacy and rules governing any information seen, heard, and/or accessible during the course of this conference.
- I agree not to exhibit or divulge the contents of any record or report discussed during this conference except as necessary and appropriate and as permitted by federal, state and local laws and to comply with all applicable policies of the hospitals at which this conference takes place.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please return this form to Jennifer Troyanovich at the Central Illinois Neuroscience Foundation  
Fax: 309.663.2344 • Email: [jtroyanovich@hotmail.com](mailto:jtroyanovich@hotmail.com)