Memorial Hermann Corporate Compliance:
Accessing the Standards of Conduct and False Claims Policy

Corporate Compliance Program
Recognizing the complexity of the various federal, state, and local laws regulating health care, Memorial Hermann Health System has adopted a Corporate Compliance Program. This Program is designed to assist the Board, the System and its employees, medical staff members, and independent contractors to maintain compliance through responsive educational programs, internal monitoring and reporting mechanisms, and Standards of Conduct. To learn more about the Memorial Hermann Corporate Compliance Program, visit https://www.memorialhermann.org/legal/corporate-compliance. If you have any questions or concerns regarding compliance, please contact the Compliance Department at 713-338-4322 or call the Corporate Compliance Helpline at 713-338-4140 or 1-877-448-4140 (toll-free).

Standards of Conduct
The Standards of Conduct adopted by Memorial Hermann are intended to ensure we meet our compliance goals in a highly regulated business environment. The Standards of Conduct create a uniform code and provide general guidance when ethical questions arise in the course of your work. Everyone, including employees, medical staff, contractors, vendors, etc., must observe the Standards of Conduct. Access the Standards of Conduct, which are updated periodically, via the Memorial Hermann website. Visit https://www.memorialhermann.org/legal/corporate-compliance and select the "Standards of Conduct" link at the bottom of the webpage.

False Claims Policy
In accordance with the requirements of the Deficit Reduction Act of 2005, Memorial Hermann has developed a False Claims Policy. This policy states that Memorial Hermann is committed to complying with all applicable laws and regulations, supports the efforts of federal and state authorities in identifying incidents of fraud and/or abuse and has the necessary procedures in place to prevent, detect, report and correct incidents of fraud and/or abuse in accordance with contractual, regulatory and statutory requirements. You are responsible for complying with the Memorial Hermann False Claims Policy, which can be accessed via the Memorial Hermann website. Visit https://www.memorialhermann.org/legal/corporate-compliance and select the "False Claims Policy" link at the bottom of the webpage.

Acknowledgement of Standards of Conduct and False Claims Policy

I have received notification of and I will read and follow the Memorial Hermann Standards of Conduct and the Memorial Hermann False Claims Policy. I have received instructions regarding how to access these documents. I understand that the Standards of Conduct apply to my relationship with Memorial Hermann and that following all laws, regulations, policies and the Standards of Conduct is a condition of that relationship. I will seek advice from my Memorial Hermann supervisor, another manager or the Chief Compliance Officer, or I will call the Compliance Helpline with any compliance questions or issues.

My signature means that I acknowledge that it is my responsibility to read and comply with the procedures and policies set forth in the Standards of Conduct and with any new or revised policies located therein. I also acknowledge that it is my responsibility to read and comply with the Memorial Hermann False Claims Policy.

Signature _____

Printed Name _____ Date _____

Position and Department/Division _____

HIPAA – Confidentiality of Protected Health Information

Memorial Hermann Health System
Volunteer Confidentiality Agreement

IMPORTANT: Please read all sections. If you have any questions, please ask before signing.

1. **Confidentiality of Patient Information**
   As a hospital Volunteer, I understand and acknowledge that: (i) services provided to patients are private and confidential; (ii) to enable such services to be performed, patients provide personal information with the expectation that it will be kept confidential and used only by authorized persons as necessary; (iii) all personally identifiable information provided by patients or regarding medical services provided to patients, in whatever form such information may exist, including oral, written, printed, photographic and electronic formats (collectively, the "Confidential Information") is strictly confidential and is protected by federal and state laws and regulations that prohibit its unauthorized use or disclosure; and (iv) in the course of my volunteer activities with Memorial Hermann Health System, I may see or learn of Confidential Information.

2. **Disclosure, Use and Access**
   I agree that, except as authorized in connection with my volunteer assignment, I will not at any time use, access or disclose any Confidential Information to any person (including but not limited to other volunteers, friends and family members). I understand that this obligation remains in full force during the entire period of my volunteer activities and continues in effect after my volunteer activities.

3. **Confidentiality Policies**
   I agree that, even though I am a volunteer, I must and will comply with the same confidentiality policies that apply to all staff at the hospitals(s).

4. **Return of Confidential Information**
   At the end of my volunteer work, or at any other time upon request, I agree to promptly return to Memorial Hermann Health System all copies of any Confidential Information then in my possession or control (including all printed and electronic copies).

5. **Periodic Certification**
   I understand that I am required to provide a written certification each year that I have complied in all respects with this Agreement. Such written certification will be on a form provided by Memorial Hermann.

6. **Requirement**
   I understand that my agreement to abide by the confidentiality policies, and this Agreement, is a condition of my volunteer activities with Memorial Hermann Health System. I understand that failure to comply with confidentiality policies will result in my no longer being accepted for volunteer activities.

_____ _____
Signature Date

_____
Printed Name

HIPAA – Confidentiality of Protected Health Information
Supplemental Form

IMPORTANT: Please read all sections. If you have any questions, please ask before signing.

Confidentiality of Patient Information (Initial Each Section)	**Initials**
1) ***I WILL NOT*** **email** patient identifiable health information outside of the Memorial Hermann Network. (Patient identifiable information includes, but not limited to: name, date of birth, medical record number and/or account number, insurance member ID#, financial information such as SS# or credit card information and any other number of name that could identify the patient).	
2) ***I WILL NOT*** **print out or copy** patient identifiable health information and take outside of Memorial Hermann facilities.	
3) ***I WILL NOT*** **share** patient identifiable health information with anyone who does not have a treatment relationship with the patient.	
4) ***I WILL NOT*** **copy** any patient identifiable health information to personal computers or thumb/jump drives, etc.	
5) ***I WILL NOT*** send attachments to personal emails with patient identifiable health information.	
6) ***I WILL NOT*** **post** ANY information regarding a patient of Memorial Hermann to any social media platforms. This includes any reference to a patient's presence at any Memorial Hermann facility even if the information does not identify the patient.	

I understand and acknowledge that: (i) the restrictions and obligations I have accepted under this Agreement are reasonable and necessary in order to protect the privacy interests of patients and the Memorial Hermann Health System. I, therefore, understand that Memorial Hermann Health System may prevent me from violating this Agreement by any legal means available including, but not limited to, denying me access to Memorial Hermann facilities or patient identifiable information, any corrective action measures applicable under Memorial Hermann policies and procedures or an institutional affiliation agreement and availing itself of any remedies from a court with jurisdiction in the matter.

_____ _____

Signature Date

_____

Printed Name

MEMORIAL HERMANN HEALTH SYSTEM
PHOTOGRAPHIC OR RECORDING CONSENT, RELEASE AND WAIVER

I,_____(print full name), consent to photographs or recordings of me as described below, and **irrevocably grant*** to Memorial Hermann Health System, its affiliates, licensees, successors and assignees, and those acting with its permission or authority (collectively referred to as "MH"), with respect to the photographs, film, audio, electronic media or tape taken of me by, or on behalf of MH, ("Pictures or Works"), the unrestricted absolute, perpetual, worldwide right to:

(1) Create the Pictures or Works for the following specific circumstance:
_____;

(2) Reproduce, copy, modify, create derivatives in whole or in part, or otherwise use the Pictures or Works, or any part thereof in combination with or as a composite of other matter, including, but not limited to, text, data, images, photographs, illustrations, animation and graphics, video or audio segments of any nature, in any media or embodiment, now known or hereafter to become known, including, but not limited to, all formats of computer readable electronic magnetic, digital, laser or optical-based media;

(3) Use and permit to be used my name in connection with the Pictures or Works as MH may choose including distribution to media outlets for the purpose of providing information about MH and its services to the public; and

(4) Display, perform, exhibit, distribute, transmit or broadcast the Pictures or Works by any means now known or hereafter to become known.

Waiver and Release

I hereby waive all rights and release MH, its Board of Directors, officers, managers, employees and agents from any claim or cause of action, whether now known or unknown, for invasion of right to privacy, publicity or personality or any similar matter, or based upon or relating to the use and exploitation of the Pictures or Works.

I agree that there shall be no obligation to utilize the authorization granted by me hereunder. The terms of this authorization shall commence on the date hereof and be without limitation except as stated below.*

I agree to execute Memorial Hermann Healthcare System's Authorization for Disclosure of Protected Health Information as it applies to this release. I am aware of my privacy rights.

I warrant and represent that I am over the age of eighteen years and that I am free to enter into this agreement.

_____ _____
Signature Date

NOTE: If under the age of eighteen years, have a parent or legal guardian execute the following: I approve and agree to the foregoing. My_____(insert "son," "daughter" or "ward") is_____years of age.

_____
Signature of Parent/Guardian Signature of Witness _____

Date _____

* **I have the right to request cessation of recording or filming.**

Project:_____MSR:_____

❑ Video ❑ Still ❑ Web

Contact Information
(Only necessary if you have not completed the HIPAA Consent form.)

(Please print) Name: _____ Address: _____

Phone number: _____ _____