Confidentiality and Conflict of Interest Statement – SHIBA Coordinators & Volunteer Counselors

With regard to SHIBA Coordinator & Volunteer Counselor duties, confidentiality can be defined as the preservation of personal information shared during contact with Medicare beneficiaries and the public. All information and records shared while providing SHIBA counseling services must be treated as confidential. Records obtained by SHIBA counselors must be maintained in a confidential and secure location at all times.

In the event that a SHIBA counselor requires additional information from a person's physician, pharmacist or other medical authority, they should first review their agency specific policy regarding HIPAA (Health Insurance Portability Accountability Act) related issues.

Counselors are advised to obtain a Disclosure of Personal Medical Information form completed and signed by the individual for whom they are providing counseling services.

Disclosing information to an unauthorized person could be interpreted as negligent or reckless misconduct, and not acting within the scope of the SHIBA counselor's duties.

By signing this form I attest that,

- I will preserve the confidentiality of information shared during the course of my SHIBA Coordinator or Volunteer Counselor duties.
- I will keep information obtained from beneficiaries secure at all times.
- I will not receive financial compensation for my volunteer counseling services now or in the future.
- I will not attempt to promote my personal opinion or views with clients.
- I will not use the information gained during my contact with Medicare beneficiaries and the public for personal or professional gain.

_____ _____

Signature Date

PO Box 14480
Salem, OR 97309

(800) 722-4134

OREGON SENIOR HEALTH INSURANCE BENEFITS ASSISTANCE

SHIBA
Senior Health Insurance Benefits Assistance
shiba.oregon.gov
(800) 722-4134

CONFIDENTIALITY AGREEMENT FOR RECEIPT OF UNIQUE ID (UID)

I hereby agree and understand that I am accountable in protection of the privacy and confidentiality of the information that is disclosed to me pursuant to my use of the SHIP UID which has been assigned to me by the Centers for Medicare & Medicaid Services. This ID, along with other identifying information will allow a 1-800-MEDICARE Customer Service Representative (CSR) or participating Medicare Advantage, Coordination of Benefits or Part D Plan sponsors to disclose certain beneficiary eligibility and claims payment-specific information to me for the purpose of assisting the beneficiary. I further understand this UID is to be confidential and I am not to disclose this ID to anyone other than the CSR.

_____ _____
Counselor Signature Date

_____
Print Counselor Name

_____ _____
Volunteer Coordinator Signature (optional) Date

_____ _____
SHIP Director Signature or Designee Date