California State University
Northridge

KLOTZ STUDENT HEALTH CENTER

Pledge of Confidentiality
Personal Health Information/Patients

I, _____, understand the Klotz Student Health Center policy on confidentiality of personal health information of our patients.

In regards to my employment or association with the Klotz Student Health Center (SHC) and as an integral part of the terms and conditions of my employment, I understand that personal health information belongs to the patient. I hereby agree and pledge that I will access only that patient data which is necessary to perform contracted responsibilities. I agree not to disclose, communicate, or use any patient information in any manner other than that necessary for the provision of the contracted services. Information within the scope of contracted services will be released only to those who have signed confidentiality agreements and have a need to know.

I understand that my obligation outlined above will continue after my employment or association with the Klotz SHC ends.

I also understand that unauthorized use or disclosure of such information may result in disciplinary action including, but not limited to, termination of my employment, fines, and/or incarceration.

My signature below attests to the fact that I have read, understand, and agree to abide by the terms of this agreement.

Name: _____

Signature:_____

Date: _____

Witness signature:_____