CONFIDENTIALITY STATEMENT AND ACKNOWLEDGMENT
STUDENT / INSTRUCTOR

I understand and agree that in the performance of my duties as a student/instructor at Geary Community Hospital, I must hold all patient, personal and health information and all Hospital information in strict confidence. This information must not be repeated or discussed with anyone outside of the direct care of the patient.

As a student/instructor of Geary Community Hospital, the discrete, daily use of confidential medical information is required. Medical information, risk management, peer review, medical staff credentialing, quality assurance, and hospital proprietary information must not be treated as gossip with my fellow employees, nor disclosed to unauthorized sources outside the hospital.

I further understand that professional codes of ethics stipulate that maintaining confidentiality of patient information is a part of professional responsibility and integrity.

I understand that removal or copying of health records shall only be done upon the express written permission of the Hospital administrator or his/her designee.

I understand that some penalties for breaches of confidentiality are subject to certain provisions of state and federal law. I understand that violation of any breach of Hospital policies related to confidentiality or a breach of the professional code of ethics, except as it relates to the educational process in the classroom or at a practicum site, will result in immediate expulsion from this institution's section of this program.

By signing this statement, I am stating that I have read and understand the confidentiality information provisions contained in the Notice of Privacy Practices and agree to maintain the confidentiality of all patient information to which I am exposed to as a student/instructor.

This statement will remain on file in the Privacy Office.

_____ _____

Print Name Date

_____ _____

Signature of Student/Instructor School