

CONFIDENTIALITY STATEMENT

I, _____, acknowledge that during the course of my employment with ABC group, I will have access to records, correspondence, reports, and other information or communications that by their very nature concern patients. I acknowledge such information is confidential and that I have no right to disseminate such information in any manner, to any person, unless specifically authorized by [ABC group].

I acknowledge such information may include contents of the patient's medical record, incident reports, and other information and data regarding patient care provided at [ABC group].

I acknowledge that I have been informed, cautioned, and instructed that information concerning patients that I receive in the course of my employment at [ABC group] is strictly confidential and not to be disclosed to any unauthorized person or entity no matter the nature of the information.

I fully understand that I may not communicate to other persons or entities any information I receive in my capacity as an employee, or during my employment at [ABC group], without appropriate authorization.

I acknowledge that in the event I might disclose any such confidential information without authorization, either intentionally or inadvertently, I could be held legally responsible for the breach of confidentiality of such information.

I acknowledge that I could be disciplined by [ABC group] for this disclosure, which could result in suspension and/or termination.

I acknowledge that this confidentiality statement has been discussed with me, I fully understand its contents and I have received a copy of it.

Date _____ Signature _____



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If you would like to discuss a particular situation, please contact our risk management division at 1-888-336-2642 or riskmanagement@psicinsurance.com.

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