Hendricks Regional Health

STUDENT CONFIDENTIALITY STATEMENT

I understand and agree that while observing at Hendricks Regional Health, I may have access to verbal, written, filmed and recorded hospital and patient information. This information includes but is not limited to:

- Patient illnesses or conditions
- Information about treatments
- Written notes about a patient
- Conversations between a patient and health-care provider

I understand and agree that I must hold this information in the strictest confidence at all times both during volunteering and when with family, friends and others in the community. Students who are shadowing don't automatically have a right to see or hear confidential patient information. To see a patient's information you must have a need to know in order to perform your job such as billing, recordkeeping, etc. No matter what your intentions, friends and family do not have any right to a patient's confidential information.

I understand that I may receive disciplinary action, including legal action, if I violate this confidentiality pledge.

I guarantee by my signature that I have been informed of Hendricks Regional Health's confidentiality policy concerning private information and its treatment.

I agree to adhere to and uphold privileged information.

Student Name _____
(Printed)

Student Name _____
(Signature)

Date _____