CONFIDENTIALITY STATEMENT

I, the undersigned, desire to observe procedures/operations for the period beginning ____/____/____ and ending ____/____/____ with the _____ Department of Scott & White. I understand that during the period of training/observation, I may have access to confidential health information. I understand that all communications and records are confidential, and that I am strictly prohibited from disclosing such communications and records with anyone other than the employees of S&W responsible for my training. I will not, at anytime, remove protected health information from Scott & White. I understand that any breach of patient confidentiality may result in one or more of the following consequences:

- I may be immediately removed from Scott & White premises.
- Scott & White may report my breach of confidentiality to my employer/educational institution and the proper legal authorities.
- The patient whose confidentiality was breached may elect to file a lawsuit against me.

I also certify by my signature that I have reviewed the Introduction to HIPAA, Privacy and Security Regulations, PowerPoint presentation.

Printed Name

Signature

Date