

Medical Records Confidentiality Acknowledgment

I acknowledge that, as part of my employment or association with this organization, I may have access to confidential medical records and patient information. I understand and agree that all such information is to be kept strictly confidential and must not be disclosed, discussed, or used inappropriately, except as required in connection with fulfilling my job responsibilities and in accordance with applicable laws and organizational policies.

I understand that violation of confidentiality policies may result in disciplinary action up to and including termination of employment and possible legal consequences.

Name:

Position/Title:

Signature:

Date: