

# Patient Information Confidentiality Acknowledgment Form

Employee Name

Position/Title

Department

I acknowledge that I have been informed of my responsibility to protect the confidentiality of patient information obtained or accessed during my employment. I agree not to disclose any patient information unless authorized or required to do so by law, and to adhere to all applicable confidentiality and privacy policies.

☐ I have read and understand the above statement.

Employee Signature

Date