Medical Records Confidentiality Agreement Acknowledgement

This form serves as an acknowledgement of your responsibility to maintain confidentiality and ensure the privacy and security of all medical records and information as required by law and organizational policy.

Employee/Individual Information

Full Name

Position/Title

Department

Date

Agreement

I acknowledge that I have read, understand, and agree to abide by all policies and laws relating to the confidentiality of medical records.
I understand that unauthorized use or disclosure of patient information is strictly prohibited and subject to disciplinary action and/or legal consequences.

☐ I understand and accept the above statement.

Signature

Signature

Date