Medical Records Access Confidentiality Form

Employee/Personnel Information

Full Name

Position/Title

Department

Employee ID

Access Details

Purpose of Access

Type of Medical Records Accessed

Date(s) of Access

Confidentiality Agreement

I acknowledge that I have been granted access to confidential medical records for legitimate purposes related to my role. I agree to maintain the confidentiality of all information obtained and will not disclose or misuse any records, in accordance with applicable laws, regulations, and organizational policies.

Signature of Employee

Date

Witness Name

Signature of Witness

Date