Putnam County Department of Health
Medical Reserve Corps

Confidentiality Agreement

I, _____, by my signature below, hereby affirm that I understand the rules of patient confidentiality as governed by the Health Insurance Portability and Accountability Act (HIPAA) and by accepted standards in healthcare.

I understand that a patient's privacy is to be protected at all times, and that a patient's private personal and health information is to be shared only with other health care and public safety providers who have a need to know such information, in order to appropriately assist in, or take over, the care of said patients.

I hereby accept my ethical and legal responsibility to protect the privacy rights of patients for whom I provide or assist in medical or personal care. I will share a patient's medical and personal information only with those who must have the information to assist, in or take over, that patient's care.

Signed

Printed Name: _____ Date: _____

Signature: _____