Lower Lights Christian Health Center

CONFIDENTIALITY OF RECORDS

I have been advised by this facility of the legal necessity of protecting the privacy and confidentiality of each patient's medical record, including financial records.

I agree not to disclose any patient or chart information to third parties or persons outside this clinic, including family and friends, unless I am specifically authorized to do so by the patient in writing. I understand that this restriction extends to revealing any information over the phone.

Any significant or material breach of this confidentiality agreement shall constitute good cause for discharge from volunteering. In addition, it may subject me to liability and responsibility for any legal damages resulting from my unauthorized disclosure.

VERIFICATION OF SIGNATURE & INITIALS

I understand that this facility must maintain a file containing the signature and initials of myself in order for future verification of documentation that I may enter into the patient record.

Name/Initials/Original Date

____
Volunteer Name (printed)

____
Volunteer Signature

____
Volunteer Initials

____
Date

Reviewed Annually

Date __________ Initials __________

Date __________ Initials __________

Date __________ Initials __________

Date __________ Initials __________

Date __________ Initials __________

Date __________ Initials __________

Date __________ Initials __________

Date __________ Initials __________

Date __________ Initials __________