

**BUTLER COUNTY HEALTH CARE CENTER
DAVID CITY NE**

CONFIDENTIALITY & HIPAA PLEDGE

As a student, volunteer or acting in any other capacity in connection with Butler County Health Care Center, I pledge that I am committed to protect the confidentiality of each patient, his/her medical records, and all other private information/documents I may encounter in the course of my study or association with Butler County Health Care Center. This includes all HIPAA Rules & Regulations.

I will make certain that all charts, notes and other written, pictorial or computer information is safely stored and secured when not in use.

I will hold all discussions regarding patients and their families or BCHCC personnel only with authorized staff and only in areas that assure privacy and will encourage others to do the same.

I will not release any written, oral, pictorial or computer information to a patient's family, friends or to other agencies without proper authorization from the patient and the hospital.

I will not gossip about employees or discuss patients or their families outside the Hospital.

I acknowledge that I am morally bound by this pledge and by all relevant state laws and professional practice acts.

I have received training and education on Confidentiality and HIPAA Compliance.

YES

NO

If Yes, please explain location/source of training _____.

Printed Name _____

Signature _____ Date _____