BOONE COUNTY HEALTH CENTER

STUDENT SHADOW PLEDGE

I understand that Boone County Health Center has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information.

As a student shadow, I understand that I may come into the possession of confidential information. I understand I must comply with this agreement in order to protect the privacy of patients.

I will not disclose or discuss any patient confidential information with others, including friends or family, who do not have a need to know it.

By signing this document, I understand and agree to the above.

_____ _____

Signature of Student Date

_____

Witness