Stanford University School of Medicine
Department of Radiology
Confidentiality Statement

I, _____, (please print name) as a visitor,

- Understand that it is my legal and ethical responsibility to maintain the confidentiality of all Patient Medical Records, Employee Information, Financial Information, Proprietary Information, Confidential Information used in research, and other confidential information arising or pertaining to SHC and LPCH.
- Agree not to disclose any such information or records to any person outside SHC and LPCH without proper authorization. Information accessed and used for research, including outside presentation and publications, requires appropriate IRB review and approval as well as privacy documentation prior to access, use or disclosure.
- Understand that each time I access Protected Health Information (PHI) I will only use the Minimum Necessary Protected Health Information required to do that function of my job.
- Agree to discuss confidential information only in the work place as appropriate, and only for job related purposes, and to refrain from discussing this information outside of the work place or within the hearing of other people who do not have a need to know about the information.
- Understand that unauthorized release of confidential information may make me subject to legal action and/or disciplinary action.
- Understand that any and all references to HIV testing, such as any clinical test, laboratory or otherwise used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specially protected and that unauthorized disclosure may make me subject to legal action and/or disciplinary action.
- Understand that the law specially protects psychiatric and drug abuse records, and that unauthorized release of such information may make me subject to legal action and/or disciplinary action.
- Understand that my access to all electronic systems is audited regularly, and that any inappropriate access to information may make me subject to legal and/or disciplinary action.
- Understand that I am not to share my log-in user ID and/or password with anyone, and that any access to SHC and LPCH systems made under my log-in user ID and password is my responsibility.
- Understand that violation of any portion of the policies and procedures related to confidentiality of patient records and the Code of Conduct or any violation of federal regulations governing the patient's right to privacy may result in immediate termination of my employment/professional relationship with SHC and LPCH.

I acknowledge that I have read and understand the above statements, have discussed them with my supervisor/sponsor, and have had all my questions answered.

_____ _____
Signature Date

Please return to:

Linda Horst –linda.horst@stanford.edu
James H. Clark Center
318 Campus Drive W 3.1
Stanford, CA 94305-5441 or
Fax: 650-724-5791