

VIRGINIA REGIONAL MEDICAL CENTER
NON-DISCLOSURE STATEMENT

IMPORTANT: Please read all sections below. If you have any questions regarding this Statement, please ask them of the Virginia Regional Medical Center Human Resources Department before signing. You may receive a copy of this Statement for your own record if you so request.

DISCLOSURE OF PATIENT, PROVIDER, RESIDENT, OR EMPLOYEE INFORMATION

I, the undersigned, recognize and acknowledge:

that services the Virginia Regional Medical Center (hereinafter referred to as the Medical Center), performs for its patients, providers, residents, or employees are confidential;

that information regarding services performed by other facilities for their patients, providers, residents, or employees that is shared with the Medical Center is confidential; (hereinafter referred to as other facilities.)

that to enable the Medical Center and other facilities to perform those services, its patients, providers, residents, or employees furnish to the Medical Center or other facilities confidential information concerning their affairs:

that the good of the Medical Center and other facilities depends, among other things, upon them keeping such services and information confidential as defined by VRMC policies or all applicable state or federal laws:

that by reason of my duties, I may come into possession of information concerning the services performed for their patients, providers, residents, or employees even though I may not take any direct part in or furnish the services performed for those patients, providers, residents, or employees;

Except as directed by the Medical Center, or by any applicable Minnesota or Federal Law, I will not at any time during or after my employment, disclose any of such services or information to any person whatsoever, or permit any person whatsoever to examine or make copies of any data, reports or other documents accessed or printed by me or coming into my possession or under my control, that have in any way to do with the patients, providers, residents, or employees of the Medical Center or other facilities with which we share information.

I recognize that the disclosure and/or unauthorized changes of information by me may give rise to irreparable injury to the Medical Center, other facilities, or to the owner of such information, and that accordingly, the Medical Center, other facilities, or the owner of such information may seek any legal remedies against me which may be available, including, but not limited to, disciplinary procedures or dismissal, if applicable.

I will at all times, on and off the premises, comply with all confidentiality regulations in effect.

I have read all of the above Sections of this Statement and I understand them.

Signature

Date

Print Name

Title

Employer