
DISTRICT WORK-BASED LEARNING

<h1>STUDENT MEDICAL CONFIDENTIALITY STATEMENT</h1>
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Student Name _____ School _____
Please Print Please Print

Place of Internship: _____

To protect individual privacy, information concerning patients, fellow employees, and other medical business are of a confidential nature and must not be discussed with persons not concerned with such information.

As a student intern in the medical field, I agree to the following terms:

1. All medical records are confidential and may not be shared or discussed with anyone unless specifically told to do so by my employer.
2. Information will not be released to anyone without written consent from the patient or family member.
3. I understand that all information concerning patients must be kept where it is accessible to only the office staff.

I understand and agree that in the performance of my duties as an intern at this or any other medical site, I must hold patient, employee, or medical business in confidence. Further, I understand that intentional or involuntary violation of such confidentiality could result in possible civil action, or disciplinary action including termination of my internship.

Signature _____ Date _____