Confidentiality Agreement

Name: _____ Date: _____

Confidentiality

I must adhere to all policies and procedures while on the premises of University Medical Center of New Orleans. I understand that I may be asked at the request of patients to leave at any time deemed necessary.

I understand that I am to consider all information regarding patient care, including the presence of the patient at University Medical Center of New Orleans, as privileged and confidential information.

I commit to protect the privacy of the patient and will not divulge information of a confidential nature to other individuals not involved in the patients care.

I agree to and acknowledge that I will be under the supervision and direction of a credentialed member of the medical staff, including but not limited to a physician, dentist, oral surgeon, podiatrist, nurse practitioner, clinical psychologist or employee from patient care services of University Medical Center of New Orleans, at all times when I am in the patient treatment area, and agree to abide and comply with all directives given to me by such an individual.

I agree and acknowledge that I am in the patient treatment area at my own risk, and release University Medical Center of New Orleans from any liability or claims related to my presence in the patient treatment area.

_____	_____	_____	_____
Signature	Date	Sponsor Signature	Date