

**PROVIDENCE HOSPITALS
CONFIDENTIALITY STATEMENT**

I, _____, do hereby affirm that I will not discuss, reveal, copy, or in any manner disclose the identity or health information of any patient who has received or is receiving healthcare services from Sisters of Charity Providence Hospitals. I understand that it is illegal for me to divulge any patient-specific information in any form to any person not involved in providing health-related services to a patient at Sisters of Charity Providence Hospitals.

I understand that all patient information, including but not limited to verbal, written, and electronic information, is confidential. Both federal law and South Carolina state laws and regulations protect all information, including the identity of patients.

I hereby acknowledge and agree that I shall at all times comply with all applicable laws, including the Medical Records Security and Privacy Regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and keep all patient-specific information absolutely confidential.

I understand that reading, discussing, or otherwise using patient-specific identification and health information for other than legitimate healthcare purposes is grounds for immediate dismissal and possible legal action, including both civil lawsuits and criminal penalties.

Student Signature

Date

Student Coordinator/ Witness

Date