

Certificate of Confidentiality

I,

(Type name)

have read and understand the University of New Mexico Policy on confidentiality of individual private health information.

I acknowledge that I am aware of and understand the University of New Mexico and/or its designated healthcare facilities' policies relating to the use, collection, disclosure, storage and destruction of private health information, including policies on e-mail, fax, and other electronic devices.

In consideration of my employment or association, whether as a volunteer, or by contract or appointment, with the University of New Mexico, and as an integral part of the terms and conditions of my employment or association, I hereby agree, pledge and undertake that I will not at any time, during my employment or association with the University of New Mexico, or after my employment or association ends, access or use private health information, or reveal or disclose to any persons within or outside the University of New Mexico, any private health information except as may be required in the course of my duties and responsibilities and in accordance with applicable laws and regulations, and University of New Mexico hospitals and department policies governing proper release of an individual's private health information.

I understand that my obligations outlined above will continue after my employment or association with the University of New Mexico ends.

I further understand that my obligations concerning the protections of the confidentiality of private health information relate to all private health information whether I acquired the information through my employment or association with the University of New Mexico or any of the healthcare facilities within the University of New Mexico.

I also understand that my unauthorized use or disclosure of such information will result in disciplinary action up to and including termination of my, employment/contract/association/appointment the imposition of fines as may be required by federal or state laws, and a report to my professional regulatory body.

Sign Employee/Standardized Patient/Trainee

Click

Date

Sign Supervisor/other authorized individual

Click

Date