Nondisclosure Agreement for
Resident/Student/Employee/Volunteer

UCHealth has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their protected health information (PHI). In the course of my employment/assignment at this facility, I may come into possession of confidential patient information, even though I may not be directly involved in providing patient services.

I understand that such information must be maintained in the strictest confidence. As a condition of my employment/assignment, I hereby agree that, unless directed by my supervisor, I will not at any time during or after my employment/assignment with UCHealth disclose any patient information to any person whatsoever or permit any person whatsoever to examine or make copies of any patient reports or other documents prepared by me, coming into my possession, or under my control, or use patient information, other than as necessary in the course of my employment/assignment.

When patient information must be discussed with other health care practitioners in the course of my work, I will use discretion to ensure that such conversations cannot be overheard by others who are not involved in the patient care.

I understand that violation of this agreement may result in corrective action, up to and including discharge.

Addendum. When patient information is found to be of useful nature in our environment as a teaching facility, it will be necessary for the resident/student/employee/volunteer to get proper authorization from both UCHealth management and the affiliated school management prior to making copies of any patient reports or other documents prepared by me, coming into my possession, or under my control. For UCHealth to allow release of patient information, whether in analog or digital format for educational purposes, it will be necessary for UCHealth to de-identify patient demographics from the record prior to releasing to the resident/student/employee/volunteer. The release of this information must guarantee the confidentiality of the patient information.


DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

Name of resident/student/employee/volunteer (printed)  Name of instructor (printed)

Signature of resident/student/employee/volunteer  Signature of instructor

Date Time Date Time