CONFIDENTIALITY OF PATIENT INFORMATION

I plan to utilize electronic documentation of patient care.

I will ensure confidentiality and security of patient information by password protecting the device or program utilized.

I agree to change the password at least quarterly or following a breach of security.

I will not provide my password to anyone.

I have been informed of the Agency's Confidentiality Policy and Safeguarding of Medical Records Policy and I agree to abide by these policies.

_____ _____

Employee Date