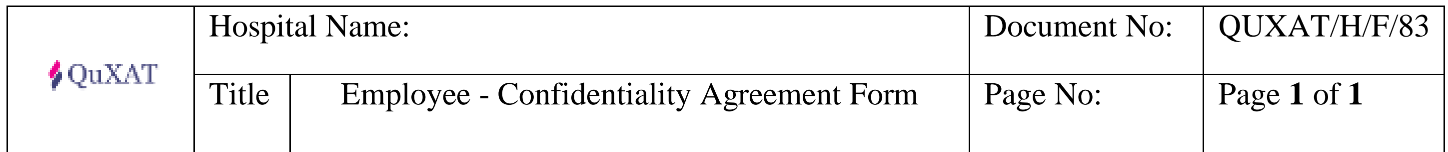

QuXAT	Hospital Name:		Document No:	QUXAT/H/F/83
	Title	Employee - Confidentiality Agreement Form	Page No:	Page **1** of **1**

Name of the Doctor/Employee/Staff: Designation:

Employee ID: Biometric ID:

Department:

Date of Joining:

I ________________________________ (Name) agree to treat all the patient information of the hospital as confidential and will protect the same from unauthorized access, use, or disclosure except to authorized individuals requiring access to such information (on prior approval by the hospital management).

If any attempt is made to obtain or use, or help in assisting others to obtain Patient Information, when unauthorized or improper would result in disciplinary action that may lead to termination from employment with the organization.

I will abide by the guidelines of the hospital to maintain confidentiality of information – pertaining to confidential patient information, which includes verbal, written, and electronic information.

Signature of Doctor/Employee/Staff:

Name:

Date:

Place:

Prepared by:	Issued by:	Reviewed by:	Approved by:	Amend Date:	Copy No:
Quality Manager	NABH Coordinator	Medical Superintendent	Medical Director	Amendment No:	
Signature:	Signature:	Signature:	Signature:	Issue Date: Issue No:	