

**Providence St. Peter Hospital
Olympia, Washington**

CONFIDENTIALITY AGREEMENT

Handling and Disclosure of Patient Information

As an employee, student, intern, observer, volunteer, or other individual acting in a capacity with Providence St. Peter Hospital, I agree to the following:

1. All files, charts, notes, and other written material concerning patients or former patients will be secured when not being used.
2. All discussions, concerning patients or former patients will be held in staff offices or other places which assure privacy.
3. No privileged information about patients or former patients will be discussed with families and/or friends.
4. For privileged information, written or verbal, to be shared with agencies or professionals, written authorization will first be obtained from the patient.
5. Access to patient files is limited to PSPH staff. Access to patient files by anyone else must be approved by appropriate management personnel.

I AM AWARE THAT NEGLECT OR REFUSAL TO FOLLOW THESE PROCEDURES MAY RESULT IN CORRECTIVE ACTION.

Signature: _____

Date: _____

Verified by: _____
(sponsor)