MEDICAL RESERVE CORPS CONFIDENTIALITY AGREEMENT

I, _____ agree that:
Volunteer Printed Name

• A client record or any information taken from a client record is privileged and confidential. In most instances, such information may not be released unless the person identified in the record provides written consent, or the release of information is otherwise permitted by law. A client record is defined as: a record of the identity that is initiated and maintained by, or at the direction of a physician, or someone under the direction or protocols of a physician.

• I understand that I must not release information from reports, records, correspondence, and other documents, however acquired, containing medical or other confidential information, and that I may not release such information except in a manner authorized by law, such as in a statistical form that will not reveal the identity of an individual or with the written consent of the individual involved.

• I may not release or make public, except as provided by law, individual case information including demographic data and client contacts.

• I will keep all confidential files, including computer diskettes, in a locked file cabinet when not in use and I will secure the information when I leave my workstation for lunch, meetings, or for the day.

• I will keep any confidential files I work with out of the view of unauthorized persons.

• I will not discuss confidential information with people who are not authorized, and/or who do not have the need or the right to know the information.

• To protect confidentiality, I will not discuss the facts contained in confidential documents in a social setting.

• When transporting information that is privileged, confidential or private, I will employ appropriate security measures to ensure the material remains protected.

• I will keep information relating internal and external activities of the department confidential. Such activities include, but are not limited to, risk assessments, survey schedules, business and trade secrets, and personnel actions.

• When I dispose of a document that contains patient or confidential information, I will assure that the document is shredded.

I have read this Confidentiality Agreement and I understand its meaning. As a volunteer of the Fort Bend County Medical Reserve Corp and Fort Bend County Health and Human Services, I agree to abide by the Confidentiality Agreement. I further understand that should I improperly release or disclose privileged, confidential, or private information, I may be subject to an adverse personnel action, up to and including the termination of my volunteer assignment. In addition, I understand that I may be subject to civil monetary penalties, criminal penalties or liability for money damages for such an action

_____ _____
Volunteer Signature Date

_____ _____
Witness Signature Date