Assurance of Patient Confidentiality

As an employee, student, volunteer, or acting in any other capacity in connection with the Free Clinic of Southwest Washington, I agree to the following:

1. All records, notes and other written material concerning patients will be maintained in the file area when not in use. These records will not be left at an employee's desk or any other area of the clinic.

2. Discussions regarding patients will be held in staff offices or other places which assure privacy.

3. No privileged information about patients will be discussed with family, friends, or any other unauthorized persons.

4. For privileged information, written or verbal, to be shared with other clinics or professionals, written authorization must first be obtained from the patient. The exception is in referral with another clinic.

5. Access to patient files is limited to agency professional and clerical staff. Access to consumer files by anyone else must be approved by the Executive Director.

6. Patient files may be removed from the offices of the Free Clinic only with approval of the Executive Director.

I have read, understand, and agree to abide by, the above confidentiality guidelines.

______________________________	______________________________	________
Volunteer's Name (please print)	Signature	Date

If the applicant is a minor on this date, parental permission is required.

I (print name) ___________________________, hereby give my permission for my minor child to participate as a volunteer with Free Clinic of SW Washington. I agree to take full legal responsibility for the minor child. I will encourage and support my minor child to meet all the requirements and commitments pursuant to this volunteer service.

______________________________	______________________________	________
Parent or Guardian (please print)	Signature	Date