UPMC Altoona Job Shadow Confidentiality Agreement

Visitor Name: ______________________________ **Visit Date:** ________________

Visit Location and Purpose: ____

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I understand that I will be taking a tour and/or be provided with a demonstration at UPMC Altoona. I understand that through the course of this tour or demonstration, I may come into contact with patient information. I understand that this information is confidential information for which UPMC Altoona is obligated under both federal and state law to keep confidential. I further understand that if I encounter patient information through the course of my tour or demonstration, it is solely for the purpose of demonstrating concepts or principles, and not for the purpose of disclosing the patient's information, condition, diagnosis, or treatment.

I agree that I will otherwise not attempt to view any patient information. I also agree that I will not copy or otherwise remove any patient information from the facility. Additionally, I agree that I will not disclose any patient information that I may come into contact with.

Signed: ____________________________________ Date: ____________________