Binghamton University
Decker School of Nursing

Decker School of Nursing (DSON) Confidentiality Agreement

IMPORTANT: Please read all sections. If you have any questions, please seek clarification before signing.

1. **Confidentiality of Patient Information**
   I understand and acknowledge that:
   a) Services provided to patients are private and confidential;
   b) Patients provide personal information with the expectation that it will be kept confidential and used only by authorized persons as necessary;
   c) All personally identifiable information provided by patients or regarding medical services provided to patients, in whatever form such information may exist, including oral, written, printed, photographic and electronic formats (collectively, the "Confidential Information") is strictly confidential and is protected by federal and state laws and regulations that prohibit its unauthorized use or disclosure; and
   d) In the course of my employment/affiliation with the DSON, I may be given access to certain Confidential Information.

2. **Disclosure, Use and Access**
   I agree that, except as authorized in connection with my assigned duties, I will not at any time use, access or disclose any Confidential Information to any person (including but not limited to co-workers, friends and family members). I understand that this obligation remains in full force during the entire term of my employment/affiliation and continues in effect after such employment/affiliation terminates.

3. **Confidentiality Policy**
   I agree that I will comply with confidentiality policies that apply to me as a result of my employment/affiliation.

4. **Return of Confidential Information**
   Upon the termination of my employment/affiliation for any reason, or at any other time upon request, I agree to promptly return to the DSON all copies of Confidential Information then in my possession or control (including all printed and electronic copies), unless retention is specifically required by law or regulation.

5. **Periodic Certification**
   I understand that I may be required to periodically certify that I have complied in all respects with this Agreement, and I agree to so certify when requested.

6. **Remedies**
   I understand and acknowledge that:
   a) The restrictions and obligations I have accepted under this Agreement are reasonable and necessary in order to protect the interests of patients, the DSON and affiliated clinical agencies; and
   b) My failure to comply with this Agreement in any respect could cause irreparable harm to patients, the DSON and affiliated clinical agencies for which there may be no adequate legal remedy. I therefore understand that the DSON or my employer may prevent me from violating this Agreement by any legal means available, in addition to disciplinary action(s) that may result in accordance with applicable DSON and Binghamton University policies and procedures.

Please check :

____ *Faculty* ____ *Staff* ____ *Student* ____ *Teaching/Research/Graduate Assistant* ____ *Employee*

Signature: _____ *Date:* _____

Printed Name: _____

3/06