



**MEDICAL INFORMATION STATEMENT OF CONFIDENTIALITY  
FOR STUDENT, VISITOR, OR HEALTH CARE INDUSTRY REPRESENTATIVE**

It is the policy of Sarasota Memorial Health Care System (SMHCS) to strictly maintain the confidentiality of all patient medical information including, but not limited to, medical record information and documentation and to protect each patient's right to privacy.

Except as provided by Hospital policy (SMHCS policy #00.PER.14, Confidential/Privileged Information), without the prior proper written and signed authorization from the patient, the patient's guardian or the patient's legal representative or as otherwise allowed by law, patient medical information shall not be inappropriately accessed, discussed, disclosed or revealed to anyone.

I clearly understand and fully agree that I shall never inappropriately access, discuss, disclose, reveal, or in any way use, either directly or indirectly, any information from a patient's medical record or medical information relating to the care and treatment of any patient treated at the Hospital. I understand that disclosure of such information may give rise to irreparable injury to Sarasota Memorial Hospital or to the owner of such information and that accordingly Sarasota Memorial Hospital or the owner of such information may seek any legal remedies available against me. I agree to indemnify and defend Sarasota Memorial Hospital against any and all liability, in the event I violate this agreement.

I also understand and agree that any violation of any portion of this Medical Information Statement of Confidentiality, applicable Policies and Procedures of Sarasota Memorial Hospital, or of state and federal laws and regulations governing confidentiality of patient medical records, medical information, or a patient's right to privacy may be cause for corrective action, including immediate termination of my experience at Sarasota Memorial Hospital, and may result in punitive damages.

My signature on this form confirms that I have carefully read, fully understand, and agree with the Medical Information Statement of Confidentiality.

\_\_\_\_\_  
Signature of student, visitor, or representative      Date

- Student
- Visitor
- Health Care Industry Representative

\_\_\_\_\_  
Printed name of student, visitor, or representative

\_\_\_\_\_  
Printed Name of Organization or Company (or N/A)

\_\_\_\_\_  
Signature of parent (s) or legally authorized      Date  
representative if Visitor is a minor

\_\_\_\_\_  
Printed Name of parent (s) or legally authorized representative