RUTGERS UNIVERSITY
HEALTH SERVICES-NB/P

SHOTS DATABASE

PATIENT CONFIDENTIALITY ACKNOWLIDGEMENT STATEMENT

THIS FORM WILL BE SIGNED AT THE TIME OF INITIAL ACCESS TO PERSONAL HEALTH INFORMATION.

I, _____, work in the _____ at Rutgers University
(Print Name) (Print Department)

and acknowledge that I have been instructed by _____ regarding confidentiality of patient information as per RUHS-NB/P Policy and Procedure # 160.91.

I understand that I may be viewing data, as part of my responsibilities for confirming student immunization status from the SHOTS database. I also understand that breach of this policy may lead to disciplinary action, up to and including dismissal. If I have any questions at any time concerning student/patient confidentiality, I will ask my Supervisor or follow-up with the Director of Quality and Compliance at RUHS-NB/P.

_____ _____
(Employee's Signature) (Date Signed)

_____ _____
(Supervisor's Signature) (Date Signed)

APL/ba