



INOVA HEALTH
SYSTEM

Inova Fairfax Hospital/ Inova Fairfax Hospital for Children

Medical Staff Confidentiality Acknowledgement Form

I hereby acknowledge, by signature below, that I understand that patient medical records and financial information, and data are to be kept confidential. I recognize that confidentiality is an ethical responsibility.

Statement:

I also understand that:

1. It is a breach of confidentiality to access any information not expressly required in the performance of my practice.
2. This information is to be held confidential and must not be shared, viewed or discussed with anyone without proper authority for the performance of his or her responsibilities.
3. In regards to my computer USER ID and Password information (as applicable):
 - a. All computer data should be maintained as confidential.
 - b. May only be used by me (the undersigned).

I accept full responsibility for any use of my USER ID and Password. I declare that I have read and understand and will abide to the above acknowledgement. Unauthorized access or disclosure of patient medical and financial information and data are grounds for disciplinary action as outlined in the IFH/IFHC Medical Staff Bylaws and Rules/Regulations and policies.

Print Name

Date

Signature

Circle one: Attending physician;
resident; medical student; AHP

Name of Trainer (if applicable)

Inova Health System Quality Policy

***Quality is doing those things necessary to meet the needs and expectations of those we serve and doing those things right every time.
We will continuously improve the ways we do our work and strive to eliminate barriers to the improvement of quality.***