

Confidentiality Agreement

Patient's health records and customer's personal information are confidential.

I understand that I may become aware of patient or customer information in the course of performing my duties
at (name of pharmacy)

and I am prohibited from divulging or communicating this information both during and after my employment.

I agree to respect the patient's right to confidentiality and privacy. I agree to access patient's personal health
information only as permitted in the performance of my duties or as otherwise directed by the pharmacist.

I agree to preserve the confidentiality of all clinical or patient information and to not divulge this information in
any form, except where authorized by the patient or required by law. Any breach, on or off duty, of this agree-
ment will be taken seriously. Any violation can or may result in legal or disciplinary action including dismissal.

I (name of employee)

acknowledge that I have read the confidentiality agreement and understand my responsibilities as they pertain to
confidentiality of personal information and agree to the principles of this agreement.

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Signature of employee

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Signature of Owner/Designated Manager

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Date