OHIO UNIVERSITY LANCASTER
MEDICAL ASSISTING TECHNOLOGY PROGRAM

CONFIDENTIALITY STATEMENT

Name of Student _____________________________

I, ________________________________________, understand the importance of patient confidentiality. I understand that a patient’s protected health information is confidential in nature and is not to be discussed, copied, or shown to anyone unless it is directly related to the patient’s medical treatment.

I understand that if I should breach a patient’s confidentiality or disclose any confidential business information belonging to the medical facility while I am involved with class assignment(s), i.e., office tour, job shadowing, or externship, that I will be immediately dismissed from the facility, receive a grade of “F” for the course(s) involved, and may be immediately terminated from the OUL MAT program. I understand that HIPAA guidelines govern my actions in a health care setting.

Signature of Student: _____________________________

Date: _____________________________

MAT Program Director: _____________________________