Confidentiality Statement

I, _____, understand that while performing my duties as an employee of Intrust Healthcare, I may have access to and/or be involved in the processing of patient care data, medical records, policies, procedures and other proprietary information, including computer files and electronic mail.

I understand that patient information I receive may only be used for clinical purposes for Intrust Healthcare to carry out the plan of care for the patient involved unless the patient or his guardian give knowledgeable consents to the release of information.

I understand that I must maintain the confidentiality of this information at all time both during and after working hours.

I understand that I will not discuss any information related to the business operations of Intrust Healthcare with anyone except authorized Intrust Healthcare personnel.

I also understand that any violation of this confidentiality may result in disciplinary action. Furthermore, I understand that I may be subject to legal action.

I certify with my signature below that I have been informed of the above policy and agree to comply fully with the confidentiality requirement.

_____ _____

Employee Signature Date

_____

Employee Social Security Number

_____ _____

Intrust Company Representative Date