**Confidentiality Acknowledgment**

I acknowledge receipt and will comply with the UConn Health policy on Confidentiality. I understand that in the performance of my duties I must hold patient, personnel and organizational information in confidence. I recognize that I have a duty to report violations of this policy. I further understand that violations of this policy are cause for disciplinary action up to and including termination. Further, I understand that I must complete any additional training as required by my department.

Your signature on this document indicates that you have received, read, understood, and will abide by all of the above information concerning the Confidentiality Policy .

Individual Signature

Date

**Please note:** The hosting department will maintain this individual's record for a minimum of 5 years from date of termination, in accordance with the state of Connecticut's record retention policy.

Revised: 4/19