Jackson Purchase Medical Associates

Consumer Confidentiality Agreement

Name: _____ SSN: _____ ___ _____

Date: _____

I acknowledge that as a participant in the clinical programs of **Jackson Purchase Medical Associates** I may gain information about other consumers. The very fact of my admission into one of their programs creates a highly likely opportunity that I will acquire personal and private information about others, which begins with the fact that other individuals are also participants in these programs, is protected by Federal Regulations **(42 C.F.R. Part 2).** I further understand that, as a condition to my admission, I herby agree, to hold this information strictly confidential, as I expect others to hold in confidence information they learn about me. I realize that this regulation prohibits me from disclosing this information to anyone outside the program, without the expressly written consent of the person to whom the information pertains. I am making this agreement of confidentiality voluntarily and understand that I am bound by this regulation for as long as I am a consumer of **Jackson Purchase Medical Associates**.

I have read and understand the statement above:

_____ _____

Signature of Consumer / Parent / Legal Guardian Date

_____ _____

Witness Date