

## UPMC VISITOR CONFIDENTIALITY AGREEMENT

Visitor Name: \_\_\_\_\_ Visit Date: \_\_\_\_\_  
(Print Name)

Visit Location and Purpose: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that I will be taking a tour and/or be provided with a demonstration at the UPMC facility mentioned above. I understand that through the course of this tour or demonstration, I may come into contact with patient information. I understand that this information is confidential information for which UPMC is obligated under both federal and state law to keep confidential. I further understand that if I encounter patient information through the course of my tour or demonstration, it is solely for the purpose of demonstrating concepts or principals, and not for the purpose of disclosing the patient's information, condition, diagnosis or treatment.

I agree that I will otherwise not attempt to view any patient information. I also agree that I will not copy, or otherwise remove any patient information from the facility. Additionally, I agree that I will not disclose any patient information that I may come into contact with.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_