
**GOAL Therapy Specialists, LLC,**
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# Confidentiality of Patient Information

I Plan to utilize electronic documentation of Patient care.

I will ensure confidentiality and security of patient information by password protecting the device or program utilized.

I agree to change the password at least quarterly or following a breach of security.

I agree not to provide my password to anyone.

I have been informed of the Agency's Confidentiality Policy and Safeguarding of Medical Records Policy and I agree to abide by these policies.

Name (Printed) _____ Date _____

Signature _____