

**THE UNIVERSITY OF KANSAS SCHOOL OF PHARMACY**  
**CONFIDENTIALITY STATEMENT**

Pharmacy practice experiences (Experiential Rotations) are required components of the academic curriculum at the School of Pharmacy of the University of Kansas, including the NTPD program. Prior to participation in any pharmacy practice experience, each student must read, and sign the following statement:

All information pertaining to patients will be maintained in the strictest confidence. This will include, but not be limited to, prescription records, patient portfolio records and any and all other information which the pharmacy practice site may have available for any given patient.

There will be no disclosure, whether in writing or verbally, of any patient information to anyone outside of the pharmacy practice site except as specifically and directly authorized by the preceptor(s) and/or the release of patient information as provided for by policy of the pharmacy practice site.

Disclosure of patient information, in writing or verbally, to other employees and/or students of the pharmacy practice site will be appropriate only when the disclosure of such information for a given patient at a specific time is consistent with the assigned task and job duties of the individual to whom the information is provided. Disclosure of information will be under the direction of the preceptor and in adherence to specific requirements of the pharmacy practice site as delineated in any policy statement of the practice site.

Records of patient information will not be copied nor removed from the premises of the pharmacy practice site except as specifically authorized by the preceptor or policy of the pharmacy practice site.

Individual patients will be permitted to review and have copies of their own records only as specifically authorized by the preceptor or the policy of the pharmacy practice site. Release of such information to relatives of patients should only be with the written approval of the individual patient and/or in adherence to policy of the practice site.

Discussion of patient records information, medical or personal, will be conducted in a professional manner with discretion and will consider privacy for the patient and/or involved health care professionals. Such discussion will pertain only to information necessary for provision of the required health care services appropriate to the specific pharmacy practice site.

I have read and understand this statement of confidentiality and hereby agree to comply with these requirements.

\_\_\_\_\_  
Pharmacy Student Name (Printed)

\_\_\_\_\_  
Pharmacy Student Signature

\_\_\_\_\_  
Date