



**School of Health Professions
Diagnostic Imaging Program**

1. I agree that I will not at any time during or after my visit to M.D. Anderson Cancer Center disclose any medical or other information.
2. I understand that MDACC is committed to protecting patient privacy and confidentiality. I understand that the information that I, as a visitor, am exposed to is presented to me in a variety of media.
3. I agree not to disclose or review patient related information.
4. I share MDACC's commitment to protect patient confidentiality and by my signature on this document, pledge compliance with the terms of the institution's policies regarding confidentiality and compliance. I understand that a person may be subject to civil or criminal legal sanctions when a violation occurs.

I have read and had a chance to ask questions regarding this agreement. I understand the terms of this agreement and agree to adhere to them.

Visitor's Name and Signature

Date

Department Representative

Date