Confidentiality Statement

Dental Assisting Program

INDIAN HILLS COMMUNITY COLLEGE
Life. Changing.

Throughout the Dental Assisting Program at Indian Hills Community College,
I, _____, will have access to patient information. I realize that this information is private and protected under HIPAA and HITECH Act 2009 and should be kept confidential. I realize that any unauthorized release of information is punishable by fine and/or imprisonment or dismissal from the program.

Throughout my education in the Dental Assisting Program at Indian Hills Community College, I will not at any time inappropriately release confidential information and I will adhere to the Code of Ethics of the Dental Assisting Program.

I understand that release of unauthorized patient information will result in immediate termination from the Indian Hills Community College Dental Assisting Program.

Name: _____

Signature: _____ Date: _____