Rady Children's Hospital San Diego

Rady Children's Hospital – San Diego
3020 Children's Way
San Diego, CA. 92123

DTF525

PATIENT INFORMATION

Name: _____
MR#: _____ Finance: _____
DOB: _____
MD: _____

Developmental Services
Confidentiality Agreement

I, _____, agree to keep confidential any information I hear or see regarding other program participants who I might observe in the course of my participation Developmental Services programs. I will not share any information about these participants with any outside persons, including family, friends, or other professionals. I understand that my therapist and other employees of Children's Hospital will not discuss other cases with me and will not discuss my child with other families.

_____ _____
Signature of Legal Guardian **Date**

_____ _____
Printed Name of Signature **Relationship to Participant**

_____ _____
Witness **Date**