

**Pregnancy Resource Medical Center of Fort Bend County**

**Confidentiality Agreement and  
Agreement to Abide by PRMC policies**

I have read the policies of the Pregnancy Resource Medical Center of Fort Bend County, and agree to abide by them and by other instruction I may be given by PRMC staff.

**I understand the vital importance of confidentiality of client information.** I agree to respect that confidentiality by refraining from disclosing to others any identifying or other detailed information concerning clients that I may become aware of during my work at PRMC.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_