Pediatric Associates, PC

CONFIDENTIALITY AGREEMENT

I have reviewed the Practice's HIPAA Privacy and Security Polices and Procedures and understand that the Practice has a legal responsibility to protect patient privacy. To do that, it must keep patient information confidential and safeguard the privacy of patient information and the privacy of electronic health information.

In addition, I understand that during the course of my employment or other work at the Practice, I may see or hear other Confidential Information, including operational and financial information, pertaining to the Practice that the Practice must maintain as confidential.

Regardless of the capacity, I understand that I must sign and comply with this Agreement in order to continue to work with the Practice.

By signing this Agreement, I understand and agree that:

I will keep patient information confidential, and I will disclose patient information only under the conditions described in the HIPAA Privacy and Security Polices and Procedures. Regarding other types of important information to the Practice, I will keep such information confidential and will only disclose such information if it is required for the performance of my job. Additionally, I will only use the Practice equipment for business purposes which are related to my job functions.

I will not discuss any information, either patient-related or relating to the Practice's operations, in public areas (even if specifics such as a patient's name are not used), unless that public area is an essential place for the performance of my job.

I will keep all security codes and passwords used to access the facility, equipment or computer systems, confidential at all times. I will not share my passwords with anyone and will safeguard my passwords at all times.

I will only access or view patient information, including my own, for that which is required to do my job. If I have any question about whether access to certain information is required for me to do my job, I will immediately ask my supervisor or the Practices' Privacy Officer for assistance.

I will not disclose, copy, transmit, inquire, modify, or destroy patient information or other System confidential information without permission from my supervisor or the Practice's Privacy Officer. This especially includes transmissions from the Practice to my home.

I recognize that I have a duty to report any suspicious activity to Security, the Help Desk, the Privacy Officer, or to the Security Officer immediately. I recognize that I have duty to report anyone who violates the HIPAA Privacy and Security Policies and Procedures to the Privacy Officer or the Security Officer. I will escort anyone who does not have an ID Badge to the Information Desk immediately. I also recognize that I have a duty to report activity suspicious for identity theft (Red Flags) to the Security Officer.

Once my job with the Practice is terminated, I will immediately return all property (e.g. keys, documents, ID badges, etc.) to the Practice. Even after my job is terminated, I agree to meet my obligations under this Agreement.

I understand that violation of this Agreement or the HIPAA Privacy and Security Polices and Procedures may result in disciplinary action, up to and including termination of my employment or relationship with the Practice, and this may include civil and criminal legal penalties as a result of the final Privacy and Security Rules issued by the federal government.

I have read the above agreement and the HIPAA Privacy and Security Polices and Procedures and agree to comply with it so that I can continue to work with the Practice.

_____ _____

Signature Date

_____ _____

Print Your Name Title