**Employee HIPAA Confidentiality Agreement**

This Health Information Confidentiality Agreement (“Agreement”) applies to all members of (Insert Name of Practice)’s workforce including staff, employees, volunteers, independent contractors, trainees and others who, in the performance of work for Covered Entity, are under Covered Entity’s direct control and who have access to protected health information (“PHI”) maintained, received, or transmitted by (Insert Name of Practice).

Please read all sections of this Agreement, in addition to (Insert Name of Practice)’s privacy and security policies and procedures, before signing below.

(Insert Name of Practice) has a legal and ethical responsibility to safeguard the privacy and protect the confidentiality of PHI it may receive, store, aggregate or transmit. In the course of your employment, you may hear information that relates to an individual’s health, read or see computer or paper files containing PHI and/or create documents containing PHI. Because you may have contact with PHI, (Insert Name of Practice) requests that you agree to the following as a condition of your employment:

1. Confidential PHI.

I understand that all health information that may in any way identify a patient or relate to a patient’s health must be maintained confidentially. I will regard confidentiality as a central obligation of my job responsibilities.

1. Prohibited Use and Disclosure.

I agree that, except as required under my job responsibilities or as directed by (Insert Name of Practice), I will not at any time during or after my work for (Insert Name of Practice) speak about or share any PHI with any person or permit any person to examine or make copies of any PHI maintained by (Insert Name of Practice). I understand and agree that personnel who have access to health records must preserve the confidentiality and integrity of such records, and no one is permitted access to the health record of any patient without a necessary, legitimate, work-related reason. I shall not, nor shall I permit any person to, inappropriately examine or photocopy a patient record or remove a patient record from (Insert Name of Practice).

1. Safeguards.

When PHI must be discussed with other healthcare practitioners in the course of my work for (Insert Name of Practice), I shall make reasonable efforts to avoid such conversations from being overheard by others who are not involved in the patient’s care.

I understand that when PHI is within my control, I must use all reasonable means to prevent it from being disclosed to others, except as otherwise permitted by this Agreement. I will not at any time reveal to anyone my confidential access codes to (Insert Name of Practice)’s information systems, and I will take all reasonable measures to prevent the disclosure of my access codes to anyone. I also understand that (Insert Name of Practice) may, at any time, monitor and audit my use of the electronic/automated patient record and information systems.

Protecting the confidentiality of PHI means protecting it from unauthorized use or disclosure in any form: oral, fax, written, or electronic. If I keep patient notes on a handheld or laptop computer or other electronic device, I will ensure that my supervisor knows of and has approved such use. I agree not to send patient identifiable health information in an email, or email attachment, unless I am directed to do so by my supervisor.

1. Training and Policies and Procedures.

I certify that I have read (Insert Name of Practice)’s policies and procedures, completed the training courses offered by (Insert Name of Practice), and shall abide by (Insert Name of Practice)’s policies and procedures governing the protection of PHI.

1. Return or Destruction of Health Information.

If, as part of my job responsibilities, I must take PHI off the premises of (Insert Name of Practice), I shall ensure that I have (Insert Name of Practice)’s express written permission to do so, I shall protect the PHI from disclosure to others, and I shall ensure that all of the PHI, in any form, is returned to (Insert Name of Practice) or destroyed in a manner that renders it unreadable and unusable by anyone else.

1. Termination.

At the end of my employment with (Insert Name of Practice), or when my assignment for (Insert Name of Practice) is otherwise terminated, I will make sure that I take no PHI with me, and that all PHI in any form is returned to (Insert Name of Practice) or destroyed in a manner that renders it unreadable and unusable by anyone else. Discharge or termination, whether voluntary or not, shall not affect my ongoing obligation to safeguard the confidentiality of PHI and to return or destroy any such PHI in my possession.

1. Sanctions.

I understand that my unauthorized access or disclosure of PHI may violate state or federal law and cause irreparable injury to (Insert Name of Practice) and harm to the patient who is the subject of the PHI and may result in disciplinary and/or legal action being taken against me, including termination of my employment.

1. Reporting of Non-Permitted Use.

I agree to immediately report to (Insert Name of Practice) any unauthorized use or disclosure of PHI by any person. The person to whom I report unauthorized uses and disclosures is the Privacy Officer (see HIPAA Compliance At-A-Glance for identity).

1. Disclosure to Third Parties.

I understand that I am not authorized to share or disclose any PHI with or to anyone who is not part of (Insert Name of Practice)’s workforce, unless otherwise permitted by this Agreement.

1. Agents of the Department of Health and Human Services.

I agree to cooperate with any investigation by the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any agent or employee of HHS or other oversight agency, for the purpose of determining whether (Insert Name of Practice) is in compliance federal or state privacy laws.

1. Disclosures Required by Law.

I understand that nothing in this Agreement prevents me from using or disclosing PHI if I am required by law to use or disclose PHI.

By my signature below, I agree to abide by all the terms and conditions of this Agreement.

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| --- | --- | --- | --- |
| *Print Full Name (first, middle initial, last)* | |  | *Signature* |
|  |  |  |  |
| *Witness* | *Date* |  | *Date Signed* |