Workforce Confidentiality Agreement

As a member of the workforce at _____, I acknowledge and understand
PRACTICE NAME
the following regarding HIPAA and patient confidentiality:

- The practice has both an ethical and legal duty to ensure the confidentiality of patient information. As a workforce member, I share this responsibility.
- As a condition of my employment, I agree to adhere to all policies and procedures related to the privacy and security of patients' protected health information (PHI).
- I will access, use, and disclose only the PHI necessary to perform my job duties. If I am uncertain about whether I should access certain information, I will immediately consult with my supervisor or the Privacy Officer.
- Any personal access codes, user IDs, and passwords assigned to me will be kept confidential at all times and will not be shared with other workforce members.
- I will not remove any PHI from the practice, in either paper or electronic form, without proper approval from my supervisor or the Privacy Officer.
- I will not disclose patient information to anyone who is not authorized to receive it, including acquaintances, friends, and family members.
- I will not disclose PHI on any social media platforms, such as Facebook or Twitter, or any other internet outlets, including any discussion or description of patients (even if the patient is not specifically identified).
- I will not transmit PHI on any mobile device without using a secure messaging application approved by the practice. This includes texting PHI to physicians, other workforce members, and patients. I understand that using the regular text messaging application on my phone to transmit PHI can result in a HIPAA violation.
- I will not email PHI using a personal email account or any email account not approved by the practice. If my job requires the use of email, I will follow the specific guidelines established by the practice.
- I will not discuss patient information with other workforce members unless I have a valid work-related reason to do so.
- I will not make any unauthorized copies, modifications, or deletions of PHI. This includes, but is not limited to, transferring PHI from the practice's computer system to an unauthorized location, such as a personal computer, USB drive, or personal email.
- Upon termination of my employment with the practice, I will immediately return all property belonging to the practice, including keys, ID badges, documents, electronic files, computer equipment, and mobile devices.
- I agree that my obligation to maintain the confidentiality of PHI will continue after the termination of my employment. I understand that knowingly using or disclosing PHI in violation of the HIPAA Privacy Rule is a criminal offense and may result in personal fines and/or imprisonment.
- Any violation of this Agreement may result in disciplinary action, up to and including termination of my employment with the practice.

I have read the above agreement and agree to comply with all its terms as a condition of my employment with the practice.

_____ _____
EMPLOYER SIGNATURE DATE

_____ _____
PRINTED NAME DATE

_____ _____
PRIVACY OFFICER SIGNATURE DATE