Confidentiality Statement

Individuals receiving healthcare services through ___________________________ have entrusted the staff and have been given the assurance that all information is held in strict confidence in accordance with legal requirements. Confidentiality applies to all patient Protected Health Information (PHI)-including patient medical information, financial information, address, phone numbers, picture or any information that can be used to identify him/her. Confidential information should not be read or discussed by any employee unless pertaining to his or her specific job requirements.

All computer system PHI information must be secured by setting screen saver passwords. Individual passwords must be secured and never shared with other employees. Secure all printed PHI. Print only that needed to perform your job or work; file this information when it is not in use. Shred all documents with PHI when they are no longer needed. Maintain patient records so the patient's name cannot be seen by non-staff.

An unauthorized disclosure of PHI or other confidential information by employees is unlawful and may subject each employee and the practice to civil and criminal liability. Disclosure of PHI or other confidential information to unauthorized persons, or unauthorized access to PHI, or misuse, theft, destruction, alteration, or sabotage of such information, is grounds for immediate disciplinary action up to and including termination. I understand that confidential information should not be read or discussed by any employee unless pertaining to his or her specific job requirements. I understand that confidential information should not be disclosed to any third party except as permitted or required under state or federal law.

Employee Confidentiality Agreement

(sign yearly)

I hereby acknowledge, by my signature below, that I understand that PHI, other confidential records, and data to which I have knowledge and access in the course of my employment with ____________________ _______ is to be kept confidential, and this confidentiality is a condition of my employment. This information should not be disclosed to anyone under any circumstances, except to the extent necessary to fulfill my job requirements. I understand confidential information should not be read or discussed unless pertaining to my specific job requirements and should not be disclosed to any third party except as permitted or required under state or federal law. I understand that my duty to maintain confidentiality continues even after I am no longer employed. I also understand that unauthorized disclosure of PHI and other confidential or proprietary information of _________ is grounds for disciplinary action, up to and including immediate dismissal.

By my signature, I validate that I have reviewed the Confidentiality Policy, the Password and E-mail policy, and the Faxing policy of ______________. I agree to uphold all confidential information and patients' rights as I perform my job.

___________________________ ______________

Signature of Employee Date

____

Print Name

___________________________ ______________

Supervisor's Signature Date