Employee Confidentiality and Security Agreement

I understand that_____, for whom I work, has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of patients' health information. In addition, the practice must ensure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems, and management information (referred to hereafter, along with patient-identifiable health information, as "confidential information").

During the course of my employment at the practice, I understand that I may come into the possession of confidential information. I will access and use this information only when it is necessary to perform my job-related duties in accordance with the practice's privacy and security policies. I further understand that I must sign and comply with this agreement in order to obtain authorization for access to confidential information.

1. I will not disclose or discuss confidential information with others, including family or friends, who do not need to know it.

2. I will not divulge, copy, release, sell, loan, alter, or destroy confidential information except as properly authorized.

3. I will not discuss confidential information where others can overhear the conversation. It is not acceptable to discuss confidential information, even if the patient's name is not used.

4. I will not make unauthorized transmissions, inquiries, modifications, or purging of confidential information.

5. I agree that my obligations under this agreement will continue after termination of my employment, expiration of my contract, or cessation of my relationship with the practice.

6. Upon termination, I will immediately return documents or media containing confidential information to the practice.

7. I understand that I have no right to ownership interest in any information accessed or created by me during my relationship with the practice.

8. I will act in the best interests of the practice and in accordance with its HIPAA compliance program at all times during my relationship with the practice.

9. I understand that violation of this agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, or termination of authorization to work within the practice, in accordance with the practice's policies.

10. I will only access or use systems or devices I am officially authorized to access and will not demonstrate the operation or function of systems or devices to unauthorized individuals.

11. I understand that I should have no expectation of privacy when using the practice's information systems. The practice may log, access, review, and otherwise use information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.

12. I will practice good workstation security measures, such as locking up disks when not in use, using screensavers with activated passwords appropriately, and positioning screens away from public view.

13. I will practice secure electronic communications by transmitting confidential information only to authorized entities, in accordance with approved security standards.

14. I will:
    a. Use only my officially assigned user ID and password;
    b. Use only approved licensed software; and
    c. Use a device with virus protection software.

15. I will never:
    a. Share or disclose user IDs or passwords;
    b. Use tools or techniques to break or exploit security measures; or
    c. Connect to unauthorized networks through the systems or devices.

16. I will notify the practice's privacy officer or security officer if my password has been seen, disclosed, or otherwise compromised, and I will report activity that violates this agreement or privacy and security policies and any other incident that could have an adverse effect on confidential information.

By signing this document, I acknowledge that I have read this agreement and agree to comply with all the terms and conditions stated above.

Employee Signature: _____

Employee Printed Name: _____

Practice Administrator Signature: _____

Practice Administrator Printed Name _____