CONFIDENTIALITY AGREEMENT
For Employees/Staff/Students/Volunteers/Observers

Name: _____
(Please print)

I understand and agree that in the performance of my duties at _____ (Name of practice), I will have access to confidential personal health information. I agree to hold all information about the practice, its clients, staff, and programs in confidence in accordance with federal and state privacy laws and office policies on HIPAA, confidentiality, and social media, which I have read and understand.

Further, I understand that intentional or involuntary violation of this confidentiality agreement may result in disciplinary action, up to and including termination of employment, as well as possible civil/criminal/administrative actions by governmental entities as a result of a violation.

The obligation to protect confidential information includes information obtained or exchanged in any format (including verbal, written, or electronic). The obligation also applies to any communications both in the course of and outside of the scope of my work.

DATE	**SIGNATURE and ROLE**

This statement will be signed at time of association with the practice and annually thereafter. This statement is to be retained in the employee/administrative files. The practice manager has the responsibility for annual reaffirmation.

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