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HIPAA EMPLOYEE CONFIDENTIALITY AGREEMENT

I acknowledge that during the course of performing my assigned duties at Whole Life Chiropractic PA, I may have access to, use, or disclose confidential health information. I hereby agree to handle such information in a confidential manner at all times during and after my employment and commit to the following obligations:

A. I will use and disclose confidential health information only in connection with and for the purpose of performing my assigned duties

B. I will request, obtain or communicate confidential health information only as necessary to perform my assigned duties and shall refrain from requesting, obtaining or communicating more confidential health information than is necessary to accomplish my assigned duties

C. I will take reasonable care to properly secure confidential health information on my computer and will take steps to ensure that others cannot view or access such information. When I am away from my workstation or when my tasks are completed, I will log off my computer or use a password-protected screensaver in order to prevent access by unauthorized users.

D. I will not disclose my personal password(s) to anyone without the express written permission of my department head or record or post it in an accessible location and will refrain from performing any tasks using another's password.

I understand that as an employee of Whole Life Chiropractic PA that is a health care provider, the use and disclosure of patient information is governed by the rules and regulations established under HIPAA, the Health Insurance Portability and Accountability Act of 1996, and related policies and procedures of. Therefore, with regard to patient information, I commit to the following additional obligations:

A. I will use and disclose confidential health information solely in accordance with the federal and office policies set forth above or elsewhere. I also agree to familiarize myself with any periodic updates or changes to such policies in a timely manner.

B. I will immediately report any unauthorized use or disclosure of confidential health information that I become aware of to the appropriate supervisor. I also understand and agree that my failure to fulfill any of the obligations set forth in this Agreement and/or my violation of any terms of this Agreement shall result in my being subject to appropriate disciplinary action, up to and including, termination of employment.

Employee Signature: _____

Employee Printed Name: _____

Date: _____

Witness Signature: _____

Witness Signature Date: _____