

**<YOUR ORGANIZATION>**

## **Policy on Confidentiality and Dissemination of Patient Information and Staff Member Verification**

Given the nature of our work, it is imperative that we maintain the confidence of patient information that we receive in the course of our work. <YOUR ORGANIZATION> prohibits the release of any patient information to anyone outside the department except in limited circumstances and discussions or disclosures of protected health information (PHI) within the organization should be limited to the minimum necessary that is needed for the recipient of the information to perform their job. Acceptable uses of PHI within the organization include but are not limited to peer review, internal audits, quality assurance and billing. I understand <YOUR ORGANIZATION> provides services to patients that are private and confidential and that I am a crucial step in respecting the privacy rights of <YOUR ORGANIZATION> patients. I understand that it is necessary, in the rendering of <YOUR ORGANIZATION> services, that patients provide personal information and that such information may exist in a variety of forms such as electronic, oral, written or photographic and that all such information is strictly confidential and protected by federal and state laws that prohibit its unauthorized use or disclosure.

I have received training in the confidentiality policies and procedures set in place by <YOUR ORGANIZATION>, listed on the back of this document and agree I will comply with such policies and procedures during my entire employment with <YOUR ORGANIZATION>. If I, at any time, knowingly or inadvertently breach the patient confidentiality policies and procedures, I agree to notify the <YOUR ORGANIZATION> HIPAA Privacy Officer Liaison immediately. In addition, I understand that breach of patient confidentiality or privacy may result in disciplinary action up to and including suspension or termination of my employment with <YOUR ORGANIZATION>. Upon separation of my employment for any reason, or at any time upon request, I agree to return any and all patient confidential information in my possession.

I have read and understand all privacy policies and procedures that have been provided to me by <YOUR ORGANIZATION OR TOWN> and <YOUR ORGANIZATION> Department. I agree to all conditions of my employment set forth in this agreement. This is not a contract of employment and does not alter the nature of the at-will employment relationship between the <YOUR ORGANIZATION OR TOWN> or <YOUR ORGANIZATION> Department and me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Policies and Procedures  
HIPAA Policy on PHI Access/Security

**<YOUR ORGANIZATION> Policy on Security, Levels of Access and Limiting Disclosure and Use of Protected Health Information**