

# Confidentiality Agreement

Effective Date: \_\_\_\_\_

- I understand that I may have direct or indirect access to confidential individually identifiable health information in the course of performing my work activities.
- I agree to protect the confidential nature of all individually identifiable health information to which I have access.
- I understand that there are state and federal laws and regulations that ensure the confidentiality of an individual's identifying health information.
- I understand that there are DHHS policies and agency procedures with which I am required to comply related to the protection of individually identifiable health information.
- I understand that my failure to observe and abide by these policies and procedures may result in disciplinary action, which may include dismissal, contract termination, and/or punishment by fine and/or imprisonment.
- I understand how I am expected to ensure the protection of individually identifiable health information. Should questions arise in the future about how to protect information to which I have access, I will immediately notify my supervisor.
- I have been informed that **this signed agreement will be retained on file for future reference.**

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_