CareAssist

HIPPA and Confidentiality Statement

I, _____ (please print name), as an employee, physician, resident, student, or volunteer at CareAssist

- Understand that it is my legal and ethical responsibility to maintain the confidentiality of all Patient Medical Records, Employee Information, Financial Information, Proprietary Information, Confidential Information used in research, and other confidential information relating to ALL CareAssist clients.

- Agree not to disclose any such information or records to any person outside without proper authorization.

- Agree to discuss confidentiality information only in the work place and only for job related purposes, and to refrain from discussing this information outside of the work place or within the hearing of other people who do not have a need to know about the information.

- Recognize that unauthorized release of confidential information may make me subject to legal action and/or disciplinary action.

- Understand that all references to HIX testing, such as any clinical test, laboratory or otherwise used to indentify HIV, a component of HIV, or antibodies or antigens to HIV, are specially protected and that unauthorized disclosure may make me subject to legal action and/or disciplinary action.

- Understand that the law specially protects psychiatric and drug abuse records, and that unauthorized release of such information may make me subject to legal action and/or disciplinary action.

- Understand that my access to all electronic systems is audited regularly, and that any inappropriate access to information may make me subject to legal action and/or disciplinary action.

- Understand that I am not to share my login or user ID and/or password with anyone, and that any access to CareAssist systems made under my login or user ID and password is my responsibility.

- Understand that violation of any portion of the policies and procedures related to confidentiality of patient records or any violation of federal regulations governing the patient's right to privacy may result in immediate termination of my employment/professional relationship with CareAssist

I acknowledge that I have read and understand the above statements, have discussed them with my supervisor, and have had all my questions answered. By signing below, I represent that I have read and understand that I am obligated to maintain the protection of patient and other confidential matters at CareAssist. Any confidential health care information that I may see, hear or otherwise access cannot be disclosed. I hereby certify that I have read this document and am aware of confidentiality requirements expected of me.

_____ _____

Employee Signature Date

_____

Employee Name ***PRINTED***