

# HIPAA Confidentiality & Information Security Agreement

I understand the facility or business entity Sabine Medical Center in or for which I work, volunteer or provide services (contractual or otherwise) has a legal and ethical responsibility to safeguard protected health information ("PHI").

In the course of my employment, assignment, or affiliation with AHM, I understand that I may come into contact with PHI, employee information and confidential business operational information.

- I agree to keep confidential all information which relates to or identifies a particular patient, employee including, but not limited to name, address, medical treatment or condition, financial status, or any other personal information which is deemed confidential according to applicable laws, ("Confidential Information").
- I will not disclose or discuss any PHI with others, including friends or family.
- I will not in any way use, access, copy, release, sell, loan, alter, remove, or destroy any PHI.
- I will not make unauthorized transmissions, inquiries, modifications, or purging of PHI.
- I will report activity that violates this agreement, privacy or security policies, or any other incident that could have any adverse impact on PHI.
- I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with AHM.
- I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, termination of authorization to work with the Company, in accordance with the Company's policies, and/or legal action against the organization and/or myself.

**Select role:**

**Employee**

**Physician**

**Contractor**

**Vendor**

**Landlord (including subcontractors)**

**Office staff**

**Student**

***I acknowledge that I have read this Agreement and I agree to comply with the terms and conditions stated above in order to obtain authorization for access to protected health information.***

Signature		Date
Printed Name	Department	