

Health Insurance Portability Accountability Act and Privacy Standards

I certify that I have completed the HIPAA privacy training with MedPlus Staffing. I further acknowledge by signature below, that I will comply with the specific policies and procedures of HIPAA and Privacy of Protected Information for each client of MedPlus Staffing in which I am assigned. I understand and will follow all of the organization=s privacy policies and procedures.

I am aware that violations of the privacy policies and procedures may result in disciplinary action up to including Termination of my employment/assignment/affiliation with (MedPlus Staffing) and /or suspension, restriction or loss of assignment in accordance with (MedPlus Staffing and MedPlus Staffing Clients) policies, as well as potential personal civil and criminal legal penalties.

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Signature

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Date

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Print Your Name

**(MEDPLUS STAFFING)**  
**CONFIDENTIALITY AGREEMENT**

I understand that **(MedPlus Staffing)** has a legal and ethical responsibility to maintain patient privacy, including obligations to protect the confidentiality of patient information and to safeguard the privacy of patient information at MedPlus Staffing Client Facilities.

In addition, I understand that during the course of my employment/assignment/affiliation at **(MedPlus Staffing)**, I may see or hear other Confidential Information such as financial data and operational information pertaining to the practice that **(MedPlus Staffing Clients)** are obligated to maintain as confidential.

As a condition of my employment/assignment/affiliation with **(MedPlus Staffing)**, I understand that I must sign and comply with this agreement.

By signing this document I understand and agree that:

I will disclose Patient Information and/or Confidential Information only if such disclosure complies with **(MedPlus Staffing and MedPlus Staffing Clients)** policies, and is required for the performance of my job.

My personal access code(s), user ID(s), access key(s), and password(s) used to access computer systems or other equipment at assigned client facilities are to be kept confidential at all times.

I will not access or view any information other than what is required to do my job. If I have any question about whether access to certain information is required for me to do my job, I will immediately ask my supervisor for clarification.

I will not discuss any information pertaining to the practice in an area where unauthorized individuals may hear such information (for example, in hallways, on elevators, in the cafeteria, on public transportation, at restaurants, and at social events). I understand that it is not acceptable to discuss any Practice information in public areas even if specifics such as a patient's name are not used.

I will not make inquiries about any practice information for any individual or party who does not have proper authorization to access such information.

I will not make any unauthorized transmissions, copies, disclosures, inquiries, modifications, or purging of Patient Information or Confidential Information. Such unauthorized transmissions include, but are not limited to, removing and/or transferring Patient Information or Confidential Information from **(MedPlus Staffing Clients)** computer system to unauthorized locations (for instance, home).

Upon termination of my employment/assignment/affiliation with **(MedPlus Staffing)**, I will immediately return all property (e.g. keys, documents, ID badges, etc.) to **(MedPlus Staffing)**.

I agree that my obligations under this agreement regarding Patient Information will continue after the termination of my employment/assignment/affiliation with **(MedPlus Staffing)**.

I understand that violation of this Agreement may result in disciplinary action, up to and including termination of my employment/assignment/affiliation with **(MedPlus Staffing)** and/or suspension, restriction or loss of privileges, in accordance with **(MedPlus Staffing and MedPlus Staffing Clients)** policies, as well as potential personal civil and criminal legal penalties.

I understand that any Confidential Information or Patient Information that I access or view at **(MedPlus Staffing Clients)** does not belong to me.

I have read the above agreement and agree to comply with all its terms as a condition of continuing employment.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Your Name