ACME CARE
Medical Clinic

ACME CARE Medical Clinic
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PATIENT CONFIDENTIALITY AGREEMENT

This Patient Confidentiality Agreement herein is signed on _____, effective _____, by and between:

(a) _____ _____, ("**Workforce Member**") resides at _____, _____ _____, _____ _____

AND

(b) _____, ("**Medical Facility**") resides at _____, _____ _____, _____ _____

Applies to all _____ *"workforce members" including: employees, medical staff and other healthcare professionals; volunteers; agency; temporary and registry personnel; trainees, house staff, students and interns.*

It is the medical facility's and its workforce's responsibility to protect and preserve the confidential patient, employee and business information. This Agreement herein is for the purpose of compliance with federal and state laws which govern the release of patient information identifiable information by hospitals and other healthcare providers, particularly the Federal Health Insurance Portability Accountability Act (HIPAA) ("**the Privacy Rule**"), the Confidentiality of Medical Information Act (California Civil Code § 56 et seq.) and the Lanterman-Petris-Short Act (California Welfare & Institutions Code § 5000 et seq.) These laws establish protections to preserve the confidentiality of various medical and personal information and specift that such information may not be disclosed except as authorized bu law or the patient or individual.

The abovementioned laws ensure the upholding of an individual's privacy rights by

protecting the individual's medical and health records by prohibiting possessors of the information from disclosing such information arbitrarily or disclosing information without the consent of the person owning such information.

Confidential patient information refers to any individually identifiable information in the possession or derived from a health care provider regarding a patient's medical history, mental/physical condition or treatment, patient/family members' records, test results, conversations, research records, financial information. These information are referred in the Privacy Rule as "protected health information". Protected health information include, but are not limited to:

- Physical, medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Patient insurance and billing records;
- Mainframe and department based computarized patient data and alphanumeric radio pager messages;
- Visual observation of patients receiving medical care or accessing services; and
- Verbal information provided by or about a patient.

Confidential Employee and Business Information includes but are not limited to:

- Employee home phone number and address;
- Name of spouse or relative;
- Social Security number or governmental identification information;
- Performance evaluation
- Other such information obtained from the medical facility's records which if disclosed would constitute an unwarranted invasion of privacy; OR
- Disclosure of confidential business information that would cause harm to the medical facility.

I understand and acknowledge that:

1. I shall maintain the confidentiality of all discussions, deliberations, patient records and any other information obtained in connection with individual patient care.
2. The security and protection of the privacy of patients have legal and ethical implications and thus I am bound by the Federal and State laws.
3. It is both my ethical and legal responsibility to protect and preserve the privacy, confidentiality and security of all medical records, proprietary information and other confidential information relating the medical facility and its affiliates, including business, employment and medical information of our patients, members, employees and healthcare providers.
4. I shall access or disclose the patient care information while performing my assigned duties by the medical facility and where required or permitted by law, only within the express approval of my supervisor or designee. I accept not to make any voluntary disclosure of any discussion, deliberation, patient care records or any other peer review or risk management information, except for the persons authorized to receive it in the conduct of the medical facility affairs. In case of uncertainty, I shall make sure to course the process with my supervisor to ensure proper protection of patient information in my possession.

5. My identification information is recorded for every use and access of patient information and I accept that I am the only one authorized to use my user ID. It shall be my responsibility to not transfer or share the utilization of my identification records such as biometrics, bar codes, QR codes, among others, for the use of any activity for another's benefit. I agree and accept to use my user ID to access the minimum necessary information to satisfy the job role or the need of the request.
6. I agree NOT to discuss confidential information outside the workplace. Any discussion about job-related purposes should only be within hearing of the persons involved.
7. I understand that information related to HIV/AIDS such as any clinical test or laboratory test used to identify HIV, a component of HIV or antibodies or antigens to HIV, psychiatry/psychology, or drug abuse is specifically protected under the law. Any unauthorized disclosure of such information may subject me to administrative and/or sanctions.
8. My responsibility and obligation of protecting any information contemplated herein shall subsist even after termination of my employment with the medical facility.
9. This agreement shall be construed and interpreted in compliance to the laws of the State of _____.

I hereby declare that I have read and I understand the foregoing information regarding this agreement. I am of legal age and with the full legal capacity to enter into an agreement. I hereby express my consent to be legally bound by this agreement by signifying my signature below.

Name of the Workforce Member

ID Number

Date

Signature

Medical Facility Representative

Department

Date

Signature

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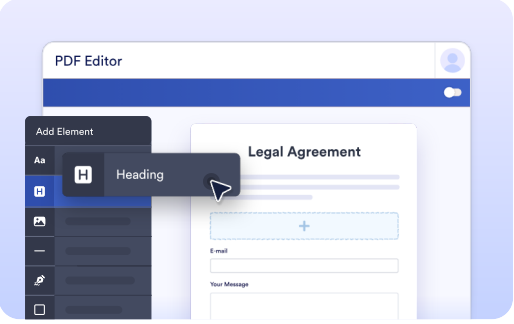

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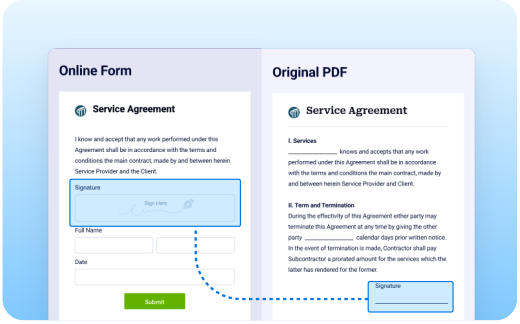

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