APPENDIX Q
CONFIDENTIALITY POLICY FORM FOR STAFF TO SIGN [1]

[Insert Name of Practice]

I understand that [Insert practice name here] 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.

In addition, I understand that during the course of my employment/assignment/affiliation at [insert practice name] I may see or hear other Confidential Information such as financial data and operational information pertaining to the practice that [practice name] is obligated to maintain as confidential.

As a condition of my employment/assignment/affiliation with [practice name] 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 [practice name's] 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 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.

[1] This template is based on the form that can be found in the APA's HIPAA Privacy Rule Manual: A Guide for Your Psychiatric Practice that is available at http://www.psychiatry.org/hipaa

- I will not make any unauthorized transmissions, copies, disclosures, inquiries, modifications, or purgings 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 [practice name's] computer system to unauthorized locations (for instance, home).

Upon termination of my employment/assignment/affiliation with [practice name] I will immediately return all property (e.g. keys, documents, ID badges, etc.) to [practice name].

I agree that my obligations under this agreement regarding Patient Information will continue after the termination of my employment/assignment/affiliation with [practice name].

I understand that violation of this Agreement may result in disciplinary action, up to and including termination of my employment/assignment/affiliation with [practice name] and/or suspension, restriction or loss of privileges, in accordance with [practice name's] 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 [practice name] 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/Physician/Student/Volunteer Date

_____

Print Your Name