Onsite
Employee Health and Wellness

HIPAA/MEDICAL INFORMATION
CONFIDENTIALITY AGREEMENT

I acknowledge that during the course of performing my assigned duties at Clarksville-Montgomery County School System On-Site Clinic, I may have access to, use, or disclose confidential health information. I hereby agree to handle such information in a confidential manner at all times during and after my employment and commit to the following obligations:

A. I will use and disclose confidential health information only in connection with and for the purpose of performing my assigned duties;

B. I will request, obtain, or communicate confidential health information only as necessary to perform my assigned duties and shall refrain from requesting, obtaining, or communicating more confidential health information than is necessary to accomplish my assigned duties;

C. I will not (1) use or further disclose any confidential health information of any patient except as provided with the prior written approval of Clarksville-Montgomery County School System On-Site Clinic or the patient; or (2) use or further disclose any confidential health information in any manner that would violate the provisions of HIPAA or its regulations;

D. I will take reasonable care to properly secure confidential health information on my computer and will take steps to ensure that others cannot view or access such information. When I am away from my workstation or when my tasks are completed, I will log off my computer or lock my computer in order to prevent access by unauthorized users;

E. I will not disclose my personal password(s) to anyone without the express written permission of my department head, and I will not record or post it in an accessible location. I will further refrain from performing any tasks using another's password;

F. I will document all disclosures of confidential health information including those authorized by patients of Clarksville-Montgomery County School System On-Site Clinic and any accidental disclosures, in the appropriate patient's file;

G. Upon termination of my employment and/or independent contract, I will return all confidential health information that I maintain in any form and will retain no copies of such information without the prior written approval of Clarksville-Montgomery County School System On-Site Clinic and/or the patient. If I am unwilling or unable to return such information, I will destroy all such information, regardless of its form, paper or electronic.

Initials: _____

Date: _____

I understand and agree that my failure to fulfill any of the obligations set forth in this Agreement and/or my violation of any terms of this Agreement shall result in my being subject to appropriate disciplinary action, up to and including, termination of employment and/or independent contract. I further understand that unauthorized use or disclosure of this information could result in the imposition of civil and criminal penalties under applicable laws, as well as professional disciplinary action.

I understand that my obligations will survive the termination of my employment and/or independent contract with Clarksville-Montgomery County School System On-Site Clinic and its patients, regardless of the reason for such termination. I understand that my obligations extend to any confidential health information that I may acquire during the course of my employment and/or independent contract with Clarksville-Montgomery County School System On-Site Clinic and its patients, whether in oral, written, or electronic form and regardless of the manner in which access was obtained.

I understand that I should contact an administrative officer of Clarksville-Montgomery County School System On-Site Clinic if I have any questions, comments, or concerns about my obligations under this agreement.

I will indemnify, hold harmless, and defend Clarksville-Montgomery County School System On-Site Clinic from and against any and all claims, losses, liabilities, costs, and other expenses incurred as a result of or arising directly or indirectly out of or in connection with any unauthorized use or disclosure of confidential health information by me.

Employee Signature: _____

Employee Printed Name: _____

Date: _____