



**Confidentiality Agreement—HIPAA Office
Hillsborough County
Acknowledgment of Special Responsibilities
as an Employee of the HIPAA Privacy Office
and Confidentiality Agreement**

Directions: This form is to be used whenever an employee is hired or transferred into the HIPAA Privacy Office. Its contents should be entered into the HIPAA compliance system by your Privacy Liaison. The form should also be filed with the employee’s personnel file.

Read this page carefully and sign the confidentiality statement to confirm that you understand its content and will safeguard protected health information (PHI).

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that protects the privacy of an individual’s health information under certain circumstances and makes it confidential. HIPAA mandates that in most instances, health information must be kept confidential unless the person gives specific written authorization or unless compelled by court order or subpoena, or when certain other conditions are met for release of health information.

By virtue of your association with the Hillsborough County Compliance Office, you may need to know and, therefore, may be informed of certain health information that is necessary to perform your assigned duties. This includes access to databases, electronic media and other media forms that contain Protected Health Information as defined by HIPAA.

By signing this form, you acknowledge that you will take all steps necessary to keep all health information confidential that you obtain or become aware of in connection with your duties and responsibilities. This includes information about any medical condition, medical testing, medical treatment or surgery, prescription medications, dental treatment or vision treatment or any other procedure related to the health of an individual. In addition, you agree not to use or disclose this information to any person except those persons directly necessary to the performance of your duties and responsibilities. If you are not sure about whether or not any information is confidential, you agree to ask your supervisor or manager.

Failure to keep health information confidential may result in monetary liability, civil penalties (fines) and/or criminal penalties provided for by law, and shall subject you to discipline up to and including dismissal, for violation of County policies.

I have read the above information and agree to keep health information confidential.

Workforce Member Printed Name: _____
First MI Last Suffix

Original Signature of Employee: _____

Date: _____

Received by _____ on _____
(Name) (date)