



**Acknowledgment of Responsibility to Maintain
Confidentiality of Medical Information**

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

By virtue of your employment or other association with Hillsborough County, you may need to access or be otherwise provided certain medical information related to others which is necessary to perform your assigned duties. Federal law, and in some instances state law, require that the personally identifiable health information you obtain be kept confidential unless the individual gives specific written authorization to disclose it or unless the information is compelled by court order or subpoena, or when certain other conditions are met for its release.

By signing this form, you formally acknowledge your complete understanding that all personally identifiable medical information you obtain or become aware of in conjunction with your work duties and responsibilities, must be kept confidential and not released by you except as allowed by law. You may neither disseminate nor discuss such medical information related to another individual with any other person except those persons directly necessary to the performance of your work duties and responsibilities. Further, you acknowledge that you are prohibited from disseminating the medical information or discussing the medical condition of another obtained in connection with your work responsibilities, unless specifically authorized to do so by a manager or an attorney in the legal department

By signing this document you acknowledge receiving notice concerning penalties any violation of the confidentiality requirements may subject you to which include discipline up to and including termination, monetary liability, and civil and/or criminal penalties imposed by law. Examples of violating the confidentiality requirements discussed above include intentional and unintentional disclosure(s) of personally identifiable medical information and penalties for intentional disclosure of medical information are the most severe pursuant to law.

Original Signature of Workforce Member

Date Signed

Workforce Member's Printed Name

Signature and printed name of witness

Date Signed

This form is to be used whenever an employee or any other workforce member has access to medical information. The signed agreement should be maintained by the Privacy Liaison.

Effective: 4/14/2003
Revised: 12/2006 and 07/2009

Post Office Box 1110
Tampa, Florida 33601

Form #AR30.01