



# The Gentle Hands Care Agency

## HIPAA Privacy/Security Agreement for Members of the Workforce.

**TGHCA is committed to protecting the confidentiality and security of information.** I may be an employee, student, trainee, volunteer, or vendor at NAHC. During the course of my duties or purpose at **TGHCA** I may have access to proprietary or confidential information. I understand that all proprietary and protected health information (collectively PHI) must be maintained confidentially, and in a secure fashion.

**I agree to follow all TGHCA policies and procedures governing the confidentiality and security of PHI in any form, including oral, fax, photographic, written, or electronic.** I will regard both confidentiality and security as a duty and responsibility while part of the **TGHCA** workforce, or during my involvement with **TGHCA** a non-workforce member. I have completed the self-study guide HIPAA training.

**I agree that I will not access, release, or share PHI, except as necessary to complete my duties or purpose at the TGHCA.** I understand that I may not access any information on friends or family members unless a Release of Information form authorizes me to do so, unless doing so is a necessary part of my job duties, or unless I am otherwise permitted to do so by **TGHCA** policies. I understand that I am not authorized to use or release PHI to anyone who is not part of the **TGHCA** workforce except as provided in **TGHCA** policies and procedures, by **TGHCA** contract, or as required by law.

**I agree that I will use all reasonable means to protect the security of PHI in my control, and to prevent it from being accessed or released, except as permitted by law.** I will use only the access privileges I have been authorized to use, and will not reveal any of my passwords or share access with others. I will take precautions to avoid inadvertently revealing PHI; for example, I will use workstations in a safe manner and will make reasonable efforts to prevent conversations from being overheard, including speaking in lowered tones and not discussing PHI in public areas. If I keep patient notes on a hand held or laptop computer or other electronic device, I will ensure that my supervisor knows of and has approved such use and I will keep this information secure and confidential. If, as part of my responsibility, I must take PHI off the premises, I will do so only with permission from my supervisor; I will protect PHI from disclosure; and will ensure that the PHI is either returned to **TGHCA** or destroyed.

**I agree that when my employment, affiliation, visitation or assignment with TGHCA ends, I will not take any PHI with me and I will not reveal any PHI that I had access to as a result of my duties at TGHCA.** I will either return PHI to **TGHCA** or destroy it in a manner that renders it unreadable and unusable by anyone else.

**I agree to report unauthorized use or disclosure of PHI, or security issues affecting systems that contain or give access to PHI** to the Privacy Officer – Human Resources Director or the Security Officer – IT Director.

**I understand that if I do not keep PHI confidential, or if I allow or participate in inappropriate disclosure or access to PHI, I will be subject to immediate disciplinary or corrective action, up to and including dismissal or loss of access privileges TGHCA property and facilities.** I understand that unauthorized access, use, or disclosure of PHI may also violate federal and state law, and may result in criminal and civil penalties.

### Acknowledgment and Compliance Statement

I, (PRINT NAME CLEARLY) \_\_\_\_\_, have received and understand the required HIPAA training materials and agree to comply with the terms above.

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_