



# Iowa Specialty Hospital

*Specializing in You*

## **CONFIDENTIALITY AGREEMENT AND TRAINING CERTIFICATION**

I may view, have access to, or otherwise come across Protected Health Information ("PHI") (as defined in the HIPAA Privacy Rule) in the performance of my job.

To ensure that all uses and disclosures of PHI that I am permitted or required to make in the performance of my job comply with the HIPAA Privacy Rule, I have read and understand the Iowa Specialty Hospital policies regarding the privacy of individually identifiable health information, as mandated by the HIPAA Privacy Rule. In addition, I acknowledge that I have received training in Iowa Specialty Hospital policies concerning the permitted and required uses and disclosures of PHI.

I hereby agree that I will not at any time use, access, or disclose PHI to any person or entity, internally or externally, except as is required in the course of my duties and responsibilities and as permitted by the Iowa Specialty Hospital HIPAA privacy policies and procedures. I understand that this obligation extends to any PHI that I may acquire during the course of my duties or association with, whether in oral, written, or electronic form, and regardless of the manner in which access was obtained.

I understand and acknowledge my responsibility to Iowa Specialty Hospital HIPAA policies and procedures during the course of my employment or association. I also understand that any unauthorized use or disclosure of PHI will result in disciplinary action, up to and including termination of my employment or association with Iowa Specialty Hospital. I understand that my obligations (as set forth in this document) will survive the termination of my employment or the end of my association with Iowa Specialty Hospital, regardless of the reason for such termination.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

HIPAA Privacy/Security Officer: \_\_\_\_\_ Date: \_\_\_\_\_