CONFIDENTIALITY & SECURITY AGREEMENT

I understand that Health Administration Advisors, LLC, in which or for whom I work, volunteer, or provide services has a relationship (contractual or otherwise) involving the exchange of health information. This organization has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of patients' health information. Additionally, assuring the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, "Confidential Information").

During my employment / assignment, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job-related duties in accordance with Privacy and Security Policies. I further understand that I must sign and comply with this Agreement to obtain authorization for access to Confidential Information. I also understand that under new HIPAA HITECH regulations, I may be personally held responsible for any breach of PHI (private health information) and any associated penalties. I am aware that such breaches involve potential financial penalties as well as incarceration under state or federal laws.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information.
4. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the organization.
5. Upon termination, I will immediately return any documents or media containing Confidential Information.
6. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities; in accordance with approved security standards, and password protect any media containing PHI.
7. I will notify my supervisor and/or the appropriate Information Technology person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.
8. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords appropriately, and positioning screens away from public view.
9. I understand that multifactor authorization access is utilized for security purposes and that I may choose to receive a code via email or my personal cell phone upon each log in verification and I consent to obtaining a code via text message.
10. I understand that no patient data to include PDF or other documents may be stored or saved or kept for any reason and that I will make sure that all browsers are closed once I am finished working.
11. I will only access or use systems or devices I am officially authorized to access and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
12. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment.

_____	____1099 Contractor_____
Printed name	Title
_____	_____
SIGNATURE	DATE