HAMILTON MEDICAL CENTER
CONFIDENTIALITY AND NON-DISCLOSURE STATEMENT

I, _____, an employee, volunteer or other member of the Workforce of Hamilton Medical Center, acknowledge that I have completed training on the Hospital's privacy policies and the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (also known as the HIPAA Privacy Rule).

- I understand that all patient information, including billing and financial data, is confidential.
- I agree to keep patient information confidential.
- I agree to comply with all Hospital Privacy Policies and Procedures including those implementing the HIPAA Privacy Rule.
- I understand that if I violate patient confidentiality by using or disclosing patient information improperly, I may be subjected to disciplinary action up to and including termination of my employment.
- I understand that if I have any questions or concerns about the Privacy Rule and/or the proper use or disclosure of patient information, I should ask my Supervisor, the Hospital Privacy Officer or the Hospital Compliance Officer.
- I understand and agree that the Hospital Privacy Policies and Procedures will apply to any patient information I have access to at the Hospital even after I terminate my employment or other relationship with the Hospital.

Signature:_____ Date:_____

Name:_____ Department:_____
(Please Print)